EXHIBIT 4

DEPOSITION OF DAVID BAZEMORE

May 15, 2007

Pages 1 through 228

PREPARED BY:

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

KYLE BENGSTON,
Plaintiff,
Vs. CIVIL ACTION NO.
3:06-cv-00569-MEF
DAVID BAZEMORE, O.D.,
et al.,

Defendants.

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DEPOSITION OF DAVID BAZEMORE, O.D., taken pursuant to stipulation and agreement before Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of Alabama at Large, in the Law Offices of Adams, Umbach, Davidson & White, 205 South 9th Street, Opelika, Alabama, on Tuesday, May 15, 2007, commencing at approximately 9:35 a.m.

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APPEARANCES

FOR THE PLAINTIFF:
Mr. David W. Adams
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FOR THE DEFENDANT:
Mr. Blake Lee Oliver
Mr. Matt White
ADAMS, UMBACH, DAVIDSON & WHITE
Attorneys at Law
205 South 9th Street
Opelika, Alabama

Also present: Mr. Kyle Bengtson

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EXAMINATION INDEX

DAVID BAZEMORE, O.D.

EXHIBIT INDEX

PLAINTIFF'S EXHIBITS

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STIPULATION

It is hereby stipulated and agreed by and between counsel representing the parties that the deposition of:

DAVID BAZEMORE, O.D.

is taken pursuant to the Federal Rules of Civil Procedure and that said deposition may be taken before Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of

commission;

That objections to questions other than objections as to the form of the question need not be made at this time but may be reserved for a ruling at such time as the said deposition may be offered in evidence or used for any other purpose by either party provided for by the Statute.

It is further stipulated and agreed by and between counsel representing the parties in this case that the filing of said deposition is hereby waived and may be introduced at the trial of this case or used in any other manner by either party hereto provided for by the Statute regardless of the waiving of the filing of the same.

It is further stipulated and agreed by and between the parties hereto and the witness that the signature of the witness to this deposition is hereby waived.

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DAVID BAZEMORE, O.D.

The witness, after having first been duly sworn to speak the truth, the whole truth and nothing but the truth testified as follows:

EXAMINATION

BY MR. ADAMS:

Q. This will be the deposition of Dr. David Bazemore, OD. Dr. Bazemore, we met in a previous deposition. My name is David Adams. I represent Kyle Bengtson.

MR. ADAMS: Same stipulations as in our prior deposition?

MR. OLIVER: Yes.

MR. WHITE: Yes.

MR. ADAMS: Let me finish the formalities. This will be taken for the purposes of discovery and any other purpose authorized by the federal civil procedure rules.

Q. Dr. Bazemore, I'm sure your attorneys have explained to you what this is about, and you've observed Kyle Bengtson's

deposition. Have you ever given a prior deposition?

A. No, sir.

Q. Okay. Well, if I ask a question that you don't understand, and I can assure you that will happen probably a number of times, not because of any inability on your part, but because I don't always ask perfect questions, please ask me to rephrase it. Because the deal is if you answer it, it's assumed you understood it.

MR. WHITE: Object to the form.

Q. If you need to take a break at any time, please feel free to just let me know or tell your attorney, and I'll be glad to accommodate you. This isn't a marathon or an endurance test, so I'll be glad to accommodate you.

Also it's important that everything you and I say be taken down by our court reporter. That means we need to respond verbally as opposed to nodding our head as we all do in normal conversation, and it

also means that word responses should be given as opposed to uh-huh and unh-unh as we're all prone to do. And I believe that's it.

All right. Can you give me your full name, Dr. Bazemore.

A. David Newell, N-E-W-E-L-L, Bazemore.

Q. Okay. Any junior or anything like that?

A. No.

Q. Okay. And where do you reside?

A. 903 McLure, M-C-L-U-R-E, Avenue, Opelika.

Q. How long have you lived there?

A. 36801.

Q. Okay.

A. Twelve or 13 years.

Q. And who lives there with you?

A. My wife.

Q. Okay. And what is her name, please?

A. Joy, the maiden name is Crawley, C-R-A-W-L-E-Y, Bazemore.

Q. Okay. And is she originally from Opelika?

A. She was born in the Philippines. When I met her, it was in Birmingham.

Q. Okay. I noticed in your interrogatory responses that you attended Opelika High School?

A. That's correct.

Q. Okay. And so I take it she didn't go to high school in Birmingham?

A. She went to high school in Richmond, Virginia.

Q. Okay. And Opelika is what I intended to say. She went to high school in Richmond, Virginia.

Does she have any relatives by blood or marriage -- well, let's just say does she have any relatives on her side of the family residing in Lee County?

A. No.

Q. Do y'all have any children?

A. Yes.

Q. And do any of them reside in Lee County?

A. One.

Q. Okay. And what's that child's name?

A. Hillary, and it's still Bazemore.

Q. Is she going to be changing her name any

Page 9

time soon that you know of?
A. Yes.
Q. Okay. And what will her new name be?
A. White.
Q. All right. And is she going to be residing in Lee County after her marriage, I assume it is?
A. I don't know.
Q. Okay. The jury may be drawn from some other counties in between here and Montgomery. Do you have any other relatives by blood or marriage that reside, say, in Montgomery County, in Macon County, in Lee County, Tallapoosa County?
A. Yes.
Q. Russell as well.
A. My mom lives here.
Q. What is her name, please?
A. Her name is Annie Merle, A-N-N-I-E, M-E-R-L-E, Bazemore.
Q. Okay.
A. I have a sister that lives here in town.
Q. What is her name, please?

Page 10

A. Her name is Carol, with a C, and the last name is White.
Q. And do you have any other children other than Hillary?
A. Three.
Q. Okay.
A. Yes.
Q. What are their names?
A. Starting with the oldest, it's Grace. Want last names?
Q. Please, yes.
A. Yukich. Y-U-K-I-C-H.
Q. Where does she live?
A. New York.
Q. Okay.
A. Shelly Spears. It's like it sounds. North Carolina.
Q. Okay.
A. And Heather still has Bazemore.
Q. Okay.
A. And that's in Birmingham. Well, it's in Pelham, if it matters.
Q. Okay. Four daughters?

Page 11

A. Yes.
Q. All right. Now, do you know if any of your four daughters intend to reside -- well, do Grace, Shelly, Heather, any of them, to your knowledge, plan to move back to this area?
A. No.
Q. Okay. Any other relatives by blood or marriage residing in the counties that I just mentioned?
A. I don't know if my sister's husband counts or something like that.
Q. Yes. What is his name?
A. His name is Terry and Carol White.
Q. Terry White?
A. Uh-huh (positive response).
Q. And where does he live?
A. Opelika.
Q. Okay. Anybody else?
A. I can't think of anybody else right off.
Q. Do you have any brothers or sisters?
A. Well, I gave you Carol, my sister.
Q. Yes, you did. Sorry about that. But no

Page 12

brothers?
A. Lives in Atlanta.
Q. Okay. I think you mentioned him.
A. Yes. We were talking last time.
Q. What is his name?
A. His name is Steve Bazemore.
Q. All right.
A. And I have another sister whose name is Susan Lazenby, Z-E-N-B-Y. And that's in Birmingham.
Q. Okay. What is your date of birth, doctor?
A. 2/21/53.
Q. And, now, we will make sure this isn't disseminated, but if you can give me your social security number.
A. 424-72-8982.
Q. Okay. Do you attend or are you a member of a church in this area?
A. Yes.
Q. Which one is that?
A. First Baptist Church in Opelika.
Q. Okay. And how long have you been a member there?

Page 13

A. We moved here in 1980, so that would be 27 years.
Q. Okay. Are you a member of any civic organization?
A. I'm not sure what you're looking for.
Q. Rotary, Civitan, anything like that?
A. No.
Q. Lion's Club?
A. (Witness shakes head from side to side.)
Q. Make sure you say no.
A. No. I'm sorry.
Q. I think you said it earlier, but maybe not to the last couple of clubs I mentioned.
Are you a member of any other organization of any type? Volunteer with anything?
A. Well, yes.
Q. Okay.
A. And that's -- I do some volunteer work for the Lion's Club and for a Mercy Medical Eye Clinic -- well, it's a medicine clinic that's down in Auburn.
Q. Okay. Are you a member of the Lion's Club?

Page 14

A. No.
Q. Okay. But you volunteer, do some work for them?
A. (Witness nods head up and down.)
MR. WHITE: Have to answer yes or no.
A. Yes.
Q. And Mercy Medical in Auburn, what is that?
A. That is a clinic that helps people that aren't able to provide for their own medical care.
Q. And what do you do with Mercy Medical?
A. I do eye exams on patients that they request me to see.
Q. How often do you do that volunteer work?
A. I couldn't really give you a number. You know, I -- there might be -- I don't know. I'd have to look back through the schedule.
Q. Okay. I mean, do you volunteer once a month or --
A. No. They come to the office.
Q. I see.
A. They call and make the appointments.

Page 15

Q. Okay. I see. And can you give me an idea of how often they might call and make that appointment?
A. Not really without looking.
Q. Okay. Would you say you see at least one patient a month under that arrangement?
A. (Witness nods head up and down.)
Q. Is that a yes?
A. Yes.
Q. Is that discounted or complete pro bono or what?
A. There's no charge to them when I see them.
Q. Okay. And you said -- you'd say it's at least once a month?
A. That would be true for the last year, you know. That's all I could say for sure.
Q. Would you say it's more than -- say more than five a month?
A. No.
Q. Okay. More than three would you say?
A. It varies from month to month. I'd hate to say without looking back through and dividing it out.

Page 16

Q. All right. But somewhere between one and five a month would be fair?
A. (Witness nods head up and down.)
Q. Is that a yes?
A. I would say -- I'm sitting here trying to think about this month and last month. I would say that's in the ballpark.
Q. Okay. Well, that's commendable that you do that.
Now, you attended Opelika High School?
A. That's correct.
Q. What year did you graduate?
A. 1971.
Q. And where did you -- what did you do after high school, immediately after high school?
A. Well, for that summer, I worked, and then in the fall I went to Auburn University.
Q. Okay. What did you study at Auburn?
A. I was in a premed curriculum. It would be a Bachelor of Science.
Q. So your degree is premed from Auburn?
A. I did not get a degree from Auburn.
Q. Okay. Where did you obtain your degree?

Page 17

A. I was accepted into optometry school in the fall of '73, I think.
Q. All right. So you attended your freshman and sophomore year at Auburn?
A. That's correct.
Q. Now, what made you decide to go to optometry school?
A. Well, my vision is not very good, and that was something that interested me, so I had applied to that early and they -- I was accepted in.
Q. Okay. Was your original plan to attend medical school?
A. Well, the curriculum is the same. There's not a pre-optometry curriculum in an undergrad program. It's the same courses.
Q. When you entered Auburn, what was your career goal?
A. At that point, I was playing basketball at the University and I was going to school and I was -- I had a pretty full schedule. I wasn't really too worried about six months from then.

Page 18

Q. Okay. But you entered premed with the idea of becoming what?
A. I thought that that would be a very interesting field to be in and would give me an opportunity to serve other people.
Q. Okay. But my question is when you decided on premed, was your vision or objective to eventually go to medical school, or was it to do something else?
A. I thought that was one of the options that I was looking at, that I thought would be very interesting.
Q. How were your grades your first two years?
A. At Auburn?
Q. Yes.
A. I think I made all A's and one B.
Q. Okay. So you were playing basketball?
A. Yes.
Q. So did you play for Bob Davis?
A. At the time that I played, they still had a freshman team.
Q. I see. Okay. Well, I'm a rare breed. I actually went to Auburn basketball games

Page 19

growing up. My dad was a bigger basketball fan than football fan, so I was in many an empty gymnasium.
You mentioned your vision was one of the things that motivated you to go to optometry school. Tell me about that.
A. Well, I am nearsighted. I have trouble seeing at a distance. And I got corrections when I was in ninth grade in high school, and it's just something that's kind of held my interest since then.
Q. Okay. When did you and your wife marry, what year?
A. You're going to get me in trouble. 1977.
Q. So you were single, playing basketball at Auburn, making good grades.
A. Correct.
Q. Okay. So what prompted you, other than your vision? Was there anything other than your vision that prompted you to want to apply to optometry school after -- around your second year of college?
A. Well, I think at that point I did not have

Page 20

anything to lose by applying there as far as trying to get in early. The worst thing they could say was no. But I was -- I was fortunate enough to be accepted early because of my performance at the undergrad level.
Q. Okay. And when you say accepted early, what do you mean by that?
A. Most of the applicants do have four-year degrees when they go in there.
Q. And was that true in 1973?
A. I couldn't tell you as far as the percentage of my class that was in -- that had a degree in this or that. I really couldn't give you those numbers.
Q. Okay. Did you apply to any other schools other than optometry school?
A. No.
Q. You didn't apply to vet school or anything like that?
A. No. I was more interested in the other.
Q. Okay. Now, did you apply anywhere other than UAB?

A. No, that was my first choice.
Q. Okay. So you weren't turned down to any optometry school?
A. No.
Q. And so you entered optometry school, you said, in the fall of '73. Now, how many years were you in optometry school?
A. That is a four-year program.
Q. All right. And what was your class rank upon graduation, do you know?
A. I was first in the class.
Q. And what did you do upon graduation?
A. I went into the Navy for three years to pay back a scholarship that I was on in school.
Q. Okay. And where were you stationed?
A. I was stationed -- I was in Beaufort, South Carolina, and I worked in the eye centers. There's a hospital there and a dispensary on one of the -- on the Parris Island base.
Q. Okay. Did you have to become a licensed optometrist to practice optometry in the military?
A. Yes.

Q. Okay. And where did you -- what state did you sit for initially?
A. When you're in -- Well, for Alabama, to answer your question.
Q. All right. So did you have to sit for a board?
A. Yes.
Q. Okay. And you had to when you graduated?
A. Well, as soon after that as it was offered.
Q. How long after you graduated was it offered?
A. I think it was either late July or August, but I couldn't -- that was 30 years ago.
Q. All right. And you graduated, I guess, May or June?
A. Early June.
Q. Okay. Did you pass the exam on the first attempt?
A. Yes, I did.
Q. Okay. And are you licensed in any other states?
A. No.
Q. Have you ever attempted to become licensed in any other states?
A. No.
Q. All right. So we re you stationed anywhere else other than Beaufort?
A. No.
Q. And, now, a fter three years, what did you do then?
A. Moved back here to Opelika.
Q. Okay. And so you graduated in 1977, moved back here in 1980?
A. Correct.
Q. And when were you discharged from the Navy?
A. In the summer of 1980.
Q. Okay. And that was honorable?
A. Right.
Q. Okay. In 1980 what did you do? What job did you take?
A. I opened my own practice of optometry, a private practice here in Opelika.
Q. And what was the name of that and where was it located?
A. It was just under my name. It was on Avenue A.

Q. How long did you practice in that arrangement?
A. It was approximately one year.
Q. All right. And what did you do after a year?
A. I was offered a position at an office, at a practice in -- it wasn't Village Mall then. In the mall in Auburn.
Q. Was that Vision World?
A. That's correct.
Q. So that was in 1981?
A. Yes.
Q. What made you decide to leave your own private practice?
A. At that time, my wife was helping me, and we had a young child and we were going to need to do something else. The people there asked me if I would come to work for them, so I did.
Q. Okay. And how many other optometry practices were there in Auburn-Opelika at that time?
A. Three, I believe.

Page 25

Q. Okay. How long were you at Vision World?
A. Twelve or 13 years.
Q. Okay. So until maybe '93 or '94?
A. Correct.
Q. What made you decide to leave there?
A. They did some things I couldn't agree with, so I found something else to do.
Q. Okay. And what do you mean by that?
A. Well, they had two locations, and they wanted to put somebody else in the second location that I had been covering for 12 or 13 years, and that was not going to leave me enough to do, so I found something else to do.
Q. Okay. Now, when you say that wasn't going to leave you enough to do, what do you mean by that?
A. Well, when I first went to work with them, they had three locations, and I was making sure that they were covered either by myself or someone else. And when that was no longer my responsibility and there was no discussion about how that would be done,

Page 26

I felt like I was going to find something else to do.
Q. Okay. Were you asked to leave?
A. No.
Q. Okay. And where were the three locations?
A. Auburn and Valley and Selma. But the Selma one was closed, so it's not open anymore.
Q. How long after you left Vision World before you joined the Wal-Mart Optometric?
A. Several months.
Q. Okay. So what month was it that you left Vision World?
A. I don't recall the exact month.
Q. Do you remember the time of the year?
A. Not right off.
Q. Okay. So you say it was '93 or '94?
A. Uh-huh (positive response).
Q. What month did you join the Wal-Mart optometry practice?
A. I'm not sure this is correct, but I think it was February.
Q. Okay. And was it a warm weather month? Was it, you know, already fall when you

Page 27

left the Vision World practice?
A. I'm not sure I understand what you're asking.
Q. That's a bad question. I'm just trying to find out. You said several months. Do you have any idea of how long it was between Vision World and Wal-Mart?
A. I couldn't tell you an exact number of months.
Q. Okay. Was it more than two?
A. Yes.
Q. Was it more than five?
A. Yes, probably so.
Q. More than nine?
A. I couldn't say.
Q. Okay. So maybe between five and nine? Does that sound right?
A. I would said possibly between six and 12.
Q. Okay.
A. I couldn't tell you any closer than that.
Q. Okay. So what were you doing for a living during that time period?
A. My wife was teaching school at that time,

Page 28

and I was working some at a Pearle Vision that was there in the mall at that time.
Q. Were you an employee of Pearle Vision?
A. No.
Q. So how many hours a week were you working?
A. It depended on how much there was to do.
Q. Did you have a specified arrangement in your contract or -- did you have a contract with them?
A. There was not a contract that dictated that I work a certain number of hours.
Q. Okay. Well, during that period between Vision World and Wal-Mart, were you ever working 40 hours a week at Pearle?
A. No.
Q. And what was the most you worked during one week at Pearle?
A. I would say -- I'm not sure. I also was helping -- I was also seeing some patients at Medical Arts Eye Clinic.
Q. Okay. And how often did you do that?
A. Maybe once or twice a week. That would be a half a day at the most.

Page 29

Q. Okay. What made you decide to join Wal-Mart?
A. I went and looked at some of the new operations that they had opened and was very pleased with the service and the cost of the service at their locations, and I thought that that was something that the people in this area would greatly benefit from, and I would like to be a part of doing that.
Q. When did the Wal-Mart that you work at open?
A. Was it '94? '93 or 4.
Q. So was it brand new when you came in?
A. Yes.
Q. Were you there the first day it opened?
A. I was there when it opened. Now, I don't remember what day of the week it opened, so if it opened on Sunday, I wasn't there. Okay? But I was there when the store opened.
Q. Okay. Was there another optometrist there working with you?

Page 30

A. No.
Q. Is there another optometrist there now?
A. No.
Q. So it's only been you the entire time?
A. Except for when I would have somebody there if I were going to be out of town.
Q. Okay. And so you are the optometrist at Wal-Mart unless you're on vacation or out of town, and then somebody covers for you, I guess?
A. Uh-huh (positive response).
Q. And that's a yes?
A. Yes.
Q. Okay. Now, how are you compensated? Are you paid by Wal-Mart?
A. No. It's an independent contract to provide services, and I pay them a certain amount of rent.
Q. Do you get a paycheck?
A. No. I get -- the way that it operates is at the end of the day, I'm given a money order for the fees that were collected that day.

Page 31

Q. From Wal-Mart?
A. There's nothing on -- I don't think there's anything on the money order that says Wal-Mart. It's just a money order like if you went in and got one, except that Wal-Mart is the payor.
Q. Okay. Do you have to work a certain number of days per week?
A. I have a contract to provide services a certain number of hours a day.
Q. How many hours is that?
A. It varies from day to day.
Q. Okay. Well, what is your contract? We can look at your contract in a minute, but do you know how many hours a day you're supposed to provide services?
A. I think -- I'm not sure. I'd have to look on there.
Q. All right.
A. It's 40 something hours, but I'm not sure.
Q. Okay. Can you -- could you subcontract out the optometry work at Wal-Mart if you wanted to? Are you free to do that?

Page 32

A. I don't think so. I've never done it, but I don't think so.
Q. Does your agreement with Wal-Mart require that you be there a certain number of weeks out of the year?
A. Not to my knowledge.
Q. Okay. Does your agreement with Wal-Mart require that you be there at a certain time of day? Do you have to be there when it opens, for instance?
A. I think probably the easiest way to help you understand that would be to say that we sit down and come up with a mutually agreeable schedule for seeing patients each week. It is not the same every day or every time.
Q. Who do you sit down with?
A. The representative from Wal-Mart, which would be what they call a district manager.
Q. And you meet with this district manager every week?
A. No.
Q. How often?

Page 33

A. I would say probably once every two months or something to that effect.
Q. Is there anybody else that you meet with or report to or whatever?
A. They have a regional manager that would be over districts that I probably see once or twice a year.
Q. Do you ever have any interaction with the store manager?
A. Very little, if any.
Q. Okay. Who gives you your money order?
A. Well, either I go down to the cash office, and whoever is working there hands it to me, or the manager of the optical part of the vision center goes down there and gets it and brings it to me. One of those two things.
Q. Okay. And what time of day do you do that? Typical day. I mean, how late is your optical center open?
A. It's open later than I'm there, but I would say the -- for me, it would usually be between 5:30 to six o'clock.

Page 34

Q. Okay. Who sees patients when you're not there in the evening?
A. I'm not -- you're talking about every day?
Q. Well, what time do you leave, typical day?
A. There's not -- there's not anyone that comes in after me and sees patients.
Q. All right. Okay. So how late do you take appointments?
A. It varies from day to day.
Q. What's the latest appointment?
A. 4:45.
Q. And are you open on Saturday?
A. Most Saturdays.
Q. How many days a week do you see patients?
A. It would probably total out to be five to five and a half total days.
Q. And how many hours a week would you say you're there at Wal-Mart?
A. It would vary from week to week, but I would say on the average it's around 45 hours.
Q. Tell me what an optometrist is exactly.
A. An optometrist is a doctor who is trained

Page 35

to examine eyes.
Q. And when you say examine eyes, can you tell me what that means?
A. To look at someone and see if their eyes are okay.
Q. And so are you looking for problems with their eyes?
A. You're looking for -- when the people come in, they are asked why they are there that day. And depending on what they're there for, there is a basic battery of tests that are done on all patients, and then some of the others may require other tests. So there's nothing that's fixed for everybody that comes in.
Q. And what are some of the eye problems that you -- that an optometrist is qualified to recognize or diagnose?
A. Well, there are all types of books full of things that we're looking for. I don't know that we have time to cover all of the things that would be, you know, answered. But mainly it's things to do with

Page 36

refractive error, which has to do with how you see, and there's also numerous health problems that can be picked up through the tests that we do.
Q. Okay. Now, what kind of health problems can you recognize by examining someone's eyes?
A. They sometimes have health problems that are related just to their eyes such as glaucoma or cataracts or other problems such as retinitis pigmentosa or other things.
There are other problems that are related to general health problems. You may pick up someone who has diabetes that didn't know it or someone that has a brain tumor that didn't know it.
Q. Since you've been an optometrist, has optometry as a field or discipline advanced in the type things optometrists are called upon to do?
A. I think that probably has advanced at a rate that would be comparable to all of the

Page 37

other health care providers; not a whole lot more or less.
Q. Is there anything that you are called upon to do as an optometrist that would be an expansion of what you were trained to do at UAB?
MR. WHITE: Object to the form. You can answer if you understand.
A. There are a lot of advances in equipment that's available to test for conditions that have been present for decades or centuries that might better enable us to, you know, diagnose and treat those problems.
Q. All right. Now, when you first became an optometrist, was there such a thing as a therapeutic license?
A. That was brought forth after I graduated.
Q. Okay. What is a therapeutic license?
A. It's a license to write prescriptions for therapeutic drugs.
Q. Is that how you're licensed? Do you have

Page 38

that license?
A. I have a therapeutic license, yes.
Q. And is there anything that you had to do to become licensed, to get the therapeutic license?
A. Yes.
Q. Okay. What did you have to do?
A. When the state law was passed, it was contingent upon your taking a certain number of CE hours that were applying only to that object, to that discussion there, and you had to pass the test at the end of that to get it.
Q. And when did you obtain your therapeutic license?
A. I'm not sure. It's been about 25 years, 23 years, something in that ballpark.
Q. So it was while you were at Vision World?
A. Correct.
Q. And did you pass that test on your first attempt?
A. Yes, I did.
Q. Are you current with your continuing

Page 39

education?
A. Yes, I am.
Q. And have you attended any continuing education course in the last five years that relates to the recognition or diagnosis or treatment of glaucoma?
A. Yes, I have.
Q. Okay. Which course was that?
A. The CE courses are typically set up to deal with multiple topics on a given weekend, and the last time that we had one that involved lectures on glaucoma was in the latter part of 2004.
Q. And where was that?
A. That one -- I don't remember. I think it was at UAB.
Q. All right. So you said the latter part of 2004?
A. It was either that or early part of 2005.
Q. So it would have been after August 20th of 2004? Is that fair?
A. I think so.
Q. Do you remember what time of the year it

Page 40

was when you were in Birmingham if that's where it was?
A. Not right off, no.
Q. Prior to that course, when was the next prior course?
A. The year before that.
Q. Okay. That would have been in the latter part of '03?
A. I'm not sure whether it was the latter or early. I go to more than one seminar every year.
Q. Okay. And when are the seminars offered every year?
A. They are offered all over the country, and they're all at different times, so I really couldn't -- you know, they have about six weekends of conferences in Birmingham alone, as well as all the others all over the place.
Q. The one you went to in the latter part of '03 or early '04, was there any discussion on the recognition and diagnosis and treatment of glaucoma? And by discussion,

Page 41

I mean was that part of the course materials?
A. The one in 2004 that I mentioned earlier, that was the topic.
Q. Okay. Prior to August 20th of 2004?
A. I'd have to look back. I couldn't say.
Q. Okay.
A. I couldn't say like this weekend was that, and this weekend was something else. I can't recall.
Q. I understand, but do you think there was any --
I think you said earlier something to the effect of that there's a broad range of topics at these seminars; is that right?
A. They're usually somewhere in the eight to 12-hour range, and typically it will be broken up into two-hour segments. So on a given weekend you might talk about glaucoma for two hours or four hours at the most, and you're going to talk about some other topics the balance of the time.
Q. Do you remember attending a seminar where

Page 42

glaucoma was discussed or was a topic prior to August of 2004?
A. I have been to many seminars that have that as a topic, but I couldn't give you a date for it.
Q. Okay. Have you ever spoken in a seminar?
A. No.
Q. Have you ever written any scholastic or practice-oriented materials?
A. Not -- nothing that was published.
Q. Okay. What have you written?
A. I haven't -- I don't recall writing anything recently. I haven't -- you know, we have local -- like you'll go down to Montgomery on Tuesday evening to something, and someone will speak down there for an hour or two about a topic.
Q. Okay. And did you write anything for that?
A. Not in a long time.
Q. Okay. Do you remember what topic you may have written on at one time?
A. Unh-unh (negative response).
Q. That's a no? Okay.

Page 43

A. No.
Q. All right. What is the standard of care for an optometrist in Alabama?
MR. WHITE: Object to the form.
A. You'd have to ask something more specific than that.
Q. Okay. Well, let me show you something I'm going to mark as Plaintiff's Exhibit 1.
(Plaintiff's Exhibit 1 was marked for identification.)
Q. This is just something that I will represent to you that I pulled off the Board of Optometry, State of Alabama's web site.
MR. WHITE: You want to give us a minute to read it? We haven't seen it before today.
MR. ADAMS: I sure do. No problem.
MR. WHITE: Just take your time and read through that.
Q. I'm not worried about '04 and '05. I'm looking at the last one there.

Page 44

MR. WHITE: You're taking about .06 there at the bottom?
MR. ADAMS: Yes, I am.
Q. Have you had a chance to read that?
A. Not finished yet.
Q. Go ahead.
MR. WHITE: Are you finished? Okay.
Q. Okay. I'm looking at this rule titled 630-X-12-.06. Have you ever seen this rule before?
MR. WHITE: First of all, can you tell us what this is from and what the source of it is?
MR. ADAMS: Sure. As I mentioned earlier, these are the rules for Alabama optometrists as found on the state board of optometry web site. And I'm sorry I don't have an original copy of their rules, but this is printed out.
MR. WHITE: This is a printout

Page 45

from the Internet from what you say is a state board of optometry web site?
MR. ADAMS: Yes And, I mean, we've been going about an hour. If you want to go print it yourself, that's fine, or we can keep going.
MR. WHITE: Why don't we do that? Let's take a break.
(Brief recess.)
Q. (Mr. Adams continuing) Dr. Bazemore, this rule -- I'll just refer to it as .06 for brevity. Prior to my handing this to you a few moments ago, had you ever seen this rule before?
A. I have seen rules about the standard of care. I don't know whether I've seen this particular one that was filed on this date. I couldn't say.
Q. All right. And during a break just now, I understand that your attorneys looked up this rule on the Internet; is that correct?

Page 46

MR. WHITE: Object to the form. That's attorney-client privilege, and we're not going to talk about what we just did on a break.
MR. ADAMS: We can talk about whether he read it or not on the break.
MR. WHITE: Talking about whether he read it right here. You can't talk about what our communications were with him during your break in our room, in closed conference.
MR. ADAMS: I'm not asking him about communication. I was going to ask him about what he did.
MR. WHITE: Anything he did in the room with us during a break is attorney-client privilege. He was there in the room with his attorneys, communicating with

Page 47

his attorneys. Whether we asked him to read something or asked him not to read something is attorney-client privilege.
MR. ADAMS: I'm not asking him what you asked him or what you said. I'm asking him did he read it on the break.
Q. Did you read over this rule during the break?
A. I've read this, you know, twice now.
Q. Okay. And prior to today, I believe your testimony is you're not sure if you've read this before; is that correct?
A. I have read the standard of care for practicing optometry in Alabama.
Q. All right. But as far as this specific rule filed on January 20th, 1992, your testimony is you don't know whether you've read this rule prior to today or not; is that correct?
A. I think I have read it.

Page 48

Q. All right. And when did you read it?
A. I've read it on more than one occasion. And the thing is that they change these some, and so -- but if this one is from '92, I've read it more than once.
Q. Okay. How often do you refer to the rules governing optometrists in Alabama?
A. I'm not sure what you're asking me.
Q. Let me -- that's fine. That's not a real good question.
Do you have a copy of the rules, of these rules in your practice?
A. I have access to it over the Internet. I don't keep a paper copy.
Q. Okay. And prior to the break just a few minutes ago, have you ever gone on the Internet to read the rules?
A. Yes, I have.
Q. How many times would you say you've done that?
A. I probably do it about once a year.
Q. Okay. And for what purpose would you do that?

Page 49

A. Just to see if it's been changed any.
Q. Okay. And when you go on the Internet, are you reading the entirety of the rules or are you mostly looking for a specific rule? I mean, kind of explain what you do.
MR. WHITE: Object to the form.
A. I can't recall that I read any specific ones as far as reading all or some each time, because that's not something I did yesterday.
Q. Okay. When you refer to the rules on the Internet, is that something you do when the need arises, or do you do it for some other reason?
A. I'll look at it periodically to try to make sure that it is still the standard of care that I understood to be applicable before that.
Q. Okay. And this rule that I'm calling .06, failure to meet the standard of care, you have had an opportunity to read through this, correct?

Page 50

A. Correct.
Q. And do you agree that this is the rule for optometrists in Alabama with respect to failure to meet the standard of care?
MR. WHITE: Object to the form.
A. I'm sorry. Could you repeat that for me one time?
Q. Do you agree that this is the rule with respect to failure to meet the standard of care for Alabama optometrists?
MR. WHITE: Let me interpose an objection here. And I'm not -- our objection is to there may be different standards of care for different circumstances. Now, if you're talking about a standard of care for a general office visit, what should be done at --
MR. ADAMS: I'm going to object to your speaking objection. Whether intended or not, I

Page 51

think it's going to have an improper effect on discovery. So I will be glad to rephrase my question.
MR. WHITE: Great. Thank you.
Q. Dr. Bazemore, as you sit here today, you're not prepared to disagree that this rule is applicable to you, correct?
A. I'm not sure I understand this to be a rule.
Q. All right. Well --
A. I haven't seen that word on here anywhere.
Q. All right. Well, that rule is not here, but you've had the opportunity to read it, correct?
A. Correct.
Q. Okay. Do you disagree that this is a standard that you must adhere to as an optometrist practicing in this state?
A. I think that this offers a standard of care to which we would all strive to at least do this if not better.
Q. Okay. So you agree, then, that it is a

Page 52

minimum standard?
A. I'm not sure that I could say a blanket statement, because I don't know what particular instance you're applying the standard to. That varies depending on what's wrong with the patient.
Q. Okay. Well, the state regulations with respect to optometrists, do you understand them to be aspirational goals or minimum standards?
A. I would think that it would be a case-to-case thing; that this is not something you could say.
Q. Do you know what I mean by aspirational goals?
A. Something that you would long to achieve?
Q. Yes, that's fair.
A. Okay.
Q. Okay. And you understand what I mean by minimum standards?
A. Yes.
Q. Okay. Just the very minimum that one should expect from an optometrist at an

Page 53

optometric visit. Is that a fair definition?
A. There is no minimum things that should be done at every office visit that comes in. It would vary depending upon the patient's needs.
Q. Well, I'll tell you what. I don't know why, but it seems like we're having trouble with this, so let me just -- I'm going to read this into the record, and you tell me if I read anything wrong. Okay?
630-X-12-.06, failure to meet standard of care. The board shall consider it unprofessional conduct for a licensee to provide for a patient care that is less than the generally accepted standard of care. This standard of care shall include but not be limited to providing certain minimum testing for the patient when performing a comprehensive eye exam. A comprehensive eye exam shall include any examination wherein a prescription for glasses or contact lenses or necessity

Page 54

thereof is determined. Minimum testing for a comprehensive eye exam shall include a case history, determination of refractive error, binocular vision evaluation, ophthalmoscopy, evaluation of health of external eye and adjacent structures, tonometry or other appropriate glaucoma testing, and such other tests as are necessary under the circumstances. Failure to perform said minimum testing during a comprehensive eye exam shall constitute failure to meet the standard of care.
Did I read this paragraph correctly?
A. I thought so, yes.
Q. Okay. I didn't misstate anything?
A. No.
Q. All right. And do you agree that this is the minimum that an optometrist should do?
A. For a comprehensive eye exam?
Q. Yes.
A. I would agree with that.
Q. Okay. So you agree that minimum testing for a comprehensive eye exam must include a

Page 55

case history?
A. Yes.
Q. Okay. And it must include a determination of refractive error?
A. Yes.
Q. All right. Let's back up. How do you go about getting a case history?
A. It depends on whether it's a new patient or a former patient. New patients are asked to fill out some questions, answer some questions that are on the registration form, and all of the patients, whether they're old or new patients, are given an oral case history.
Q. Okay. And do you ask questions of the patients?
A. Yes, I do.
Q. Okay. What questions do you ask?
A. Is this a new patient or an old patient?
Q. Well, let's take a new patient first.
A. Okay. The questions that they're asked to fill in on the sheet are whether -- well, there's several questions on there. I

Page 56

don't have one in front of me. But basically, I'm going to go back through those questions and ask them if there was any -- if there were yeses and nos on that, then I'm going to explore the yeses and see what's going on there. Then I will also ask them some other questions under an oral history and write them down on the actual front exam area of the medical record.
Q. All right. And what questions do you ask them on the oral history?
A. They're asked if they have been in before, and if so, how long it has been. They are asked why they're there today. Was it time for a routine exam, or are they having problems? If so, what kind of problem are they having? They're asked if they're on any medicine for anything or have any general health problems or if they're allergic to any medicine. They're asked if they've ever had any operations or injuries or infections or surgery on their eyes. They're asked if there's any family history

Page 57

of eye diseases or blindness in the family. They're asked if they have any general health problems, and if so, who's their medical doctor that treats those and what medications they're on and if they're allergic to any medicine.

Let's see. I'm trying to go down the list. I think that's about it.

Q. What about with an existing patient? What kind of case history?

A. My part of asking them questions would be the same.

Q. What about the forms for an existing patient?

A. The medical record part with the exam results looks the same either way. They're just asked to fill out additional sheets for their first visit.

Q. Okay. What is the purpose of a case history?

A. To identify the problems and needs of the patient and to try to remedy those.

Q. All right. And what kind of problems and

Page 58

needs are you looking for?

A. Any kind they might have.

Q. Okay. Let me just kind of back up a minute. Do you know what the leading causes of blindness are, say, in this country?

A. In this country?

Q. Yes, sir.

A. It varies from region to region, depending on the demographics of the different areas. Okay? Right now, probably the leading cause in the country as a whole is macular degeneration.

Q. Okay. What else?

A. Well, that would be the leading one.

Q. All right. Well, causes, I guess, is what I intended to ask. I may not have -- but what else is a leading cause of blindness?

A. Glaucoma would be one of the leaders and probably -- I don't know. Past there, I would be hesitant to say because they're all the time updating that every six months to a year.

Page 59

Q. Do you subscribe to any publications that keep you apprised of new developments in the optometric field?

A. Yes.

Q. What publications do you subscribe to?

A. Review of Optometry. American Optometric Association has a thing they put out monthly, a journal. Optometric Management. Vision Monday is another.

Oh, goodness. Let's see. Which ones have I said so far?

Q. Review of Optometry, American Optometric Association publication, Optometric Management, and Vision Monday.

A. Okay. There's another one called 20/20.

Q. Okay. Anything else that you take?

A. If so, I can't remember it right this minute.

Q. So of these five publications you listed, do you subscribe to all of them?

A. Yes.

Q. And is Review of Optometry -- how often does that come out?

Page 60

A. Monthly.

Q. And you said American Optometric Association is monthly?

A. Monthly.

Q. Optometric Management. How often?

A. Monthly.

Q. All right. And Vision Monday?

A. Monthly.

Q. And 20/20?

A. Same, monthly.

Q. All right.

A. The Alabama Optometric Association also puts out a newsletter that's monthly.

Q. Now, how often do you read these publications? I mean, do you read it cover to cover every month?

A. Probably most of the time.

Q. Okay. And that would go for all of them, all six of them?

A. (Witness nods head up and down.)

Q. Is that a yes?

A. Yes.

Q. All right. So based on what you were

Page 61

saying about the leading causes of blindness being macular degeneration and glaucoma, is it fair to say that two of the problems that you are looking for would be macular degeneration and glaucoma?
A. That's correct.
Q. Okay. And that would be the minimum of what an optometrist should do, correct?
A. Yes.
Q. And why is it important to recognize whether a patient may have glaucoma?
A. Well, to try to manage it and keep it from preventing loss of vision.
Q. So is it fair to say that you believe that if glaucoma goes untreated, it can result in blindness?
A. That's possible.
Q. And glaucoma, if untreated, can cause nerve damage, correct?
A. That's what the glaucoma is. It has to deal with nerve damage.
Q. Okay. And are you aware of any way -- are you aware of any medical treatment to

Page 62

reverse the effects of optical nerve damage?
A. No.
Q. Okay. How do you determine refractive error?
A. Well, there are several instruments that are used for that. There's something called an autorefractor and there's something called a retinoscope and there's something called a phoropter. There's also something called trial lenses. All of those things are used quite regularly as well as some others that are used less.
Q. Okay. And which ones do you use in the normal course of your practice?
A. All of those.
Q. Does each patient -- are they tested on each one of those?
A. If they're there for a comprehensive exam, they are.
Q. Okay. And when you are testing for refractive error, what are you looking for?

Page 63

Let me ask you this. What is refractive error?
A. Refractive error means that there is an optical problem with your eye that keeps the light from focusing on your retina properly.
Q. Okay. And how do you test for binocular vision evaluation? How do you do a binocular vision examination?
A. There are several tests that are done for that, and you just check to see how they use their eyes together.
Q. And why is that important?
A. Well, because if they don't use their eyes well together, they're missing out on having, you know, the depth perception that you get with binocular vision, as well as their vision may not be as clear.
Q. Okay. What is an ophthalmoscopy?
A. Ophthalmoscopy --
Q. Thank you.
A. -- is a test where you look into the back of their eye through their pupil.

Page 64

Q. And what are you looking for there?
A. Anything out of the ordinary.
Q. Okay. And what are some examples of things out of the ordinary that you might see using that test?
A. You may have macular degeneration we talked about earlier. They could have diabetic retinopathy. They could have a retinal detachment. They could have -- I mean, there would be a long, long, long, long, long list.
Q. Could you see -- I'm not sure how to say this. Could you see glaukomflecken? I'll bet I butchered that. How do you say that?
You're laughing at me, but that's all right.
A. No. I speak southern, so, you know...
Q. In Atlanta, they think I speak very southern.
Well, what -- can you see that using that device?
A. Can you reword what you're looking for

Page 65

there?
Q. Well, let me ask you this. I'm going to spell it. G-L-A-U-K-O-M-F-L-E-C-K-E-N. Do you know what that is?
MR. WHITE: Spell it again for him.
MR. ADAMS: Sure.
Q. G-L-A-U-K-O-M-F-L-E-C-K-E-N.
A. Okay.
Q. What is that?
A. It sounds to me --
MR. WHITE: Hold on. If you know what it is, answer the question. Don't guess if you don't know.
A. I'm not sure what they're referring to in that particular article.
MR. WHITE: Just for the record, you're reading something out of an article which you haven't presented to him, and you just asked him about a word in that article.

Page 66

MR. ADAMS: Yes. It's actually -- I will present it as an exhibit later. It's actually a chapter out of a textbook, and we'll talk about it later.
Q. So is it fair to say you're not sure whether you can visualize that glaukomflecken on an ophthalmoscopy or not, correct?
A. I couldn't say without knowing what they're referring to with the glaukomflecken.
Q. All right. Well, I can represent to you that glaukomflecken as defined in Dr. Bartlett, who --
Was he one of your professors at UAB?
A. No, he wasn't there when I was.
Q. But you know who Jimmy Bartlett is?
A. (Witness nods head up and down.)
Q. Is that a yes?
A. Yes.
Q. Okay. And you recognize him as somebody competent to write on the subject of optometry? You recognize he's a professor

Page 67

at the school you graduated from?
A. Professor at UAB.
Q. Okay. Well, according to his book, glaukomflecken -- and I'm going to use a word he doesn't use. I would say residue of prior glaucoma attacks that appear as small gray-white areas just beneath the anterior capsule of the lens in the pupillary zone.
Does that sound like something that you look for?
MR. WHITE: Object to the form. You want to just show him the article?
MR. ADAMS: I will in a minute. I'm really not trying to get specifically on this topic now. I'm just asking. I'm interested in this test and if he looks for that test.
A. Ophthalmoscopy?
Q. Yes, sir.
A. You're really not looking at the lens.

Page 68

You're looking all the way in the back at the retina.
Q. Okay. Thank you. That helps me out.
Going further in this standard here, evaluation of health of external eye and adjacent structures. How do you evaluate the health of external eye and adjacent structures?
A. I'll look at that with my eyes. I also have a little flashlight that I use to look at the area, and you also would look at some of that with the slit-lamp microscope.
Q. All right. And what are you looking for?
A. Again, that's just way too open. There would be books full of stuff.
Q. Okay. Well, let's say if you are concerned that someone may be at risk for glaucoma, what would you be looking for?
A. I would look for that in every patient that comes in the door. Okay? And you look at their iris. You look at their cornea. You look at the anterior chamber angle. You look at the lens that you were referring to

Page 69

a minute ago. You check the pressure.
Q. And you would look for those things in every patient that comes through the door because glaucoma is a serious eye disease, correct?
A. Correct.
Q. And it can result in blindness, correct?
A. It can.
Q. And irreversible damage to the optic nerve, correct?
A. That's correct.
Q. Do you ever use gonioscopy?
A. Yes.
Q. And what do you use the gonioscopy for?
A. It's used to examine the anterior chamber angle.
Q. And what are you looking for there?
A. You're looking for any kind of damage there or pigment deposition or anything that would be out of the normal.
Q. What is tonometry?
A. It measures the pressure inside your eye.
Q. And what are the different types of

Page 70

tonometry?
A. The three that are used the most are a noncontact tonometer, a Tonopen, and a Goldmann tonometer.
Q. And which ones do you use?
A. I usually use either the Goldmann or the air puff. Sometimes I'll do both on the same patient.
Q. Okay. And under what circumstances would you do both on the same patient?
A. If I'm not satisfied with the results from the first one, then I'll double check it with the other one.
Q. And why is checking eye pressure important?
A. It's one of the tests that you use in diagnosing glaucoma.
Q. And when I say eye pressure, you understand that to mean intraocular eye pressure?
A. I assumed that's what you were talking about.
Q. All right. And is one method of tonometry more favored than any other in your opinion?

Page 71

A. I use all of them, you know. And it's nice to have more than one way to do it because you can double check one thing against the other on the different types.
Q. Okay. And you've testified that the circumstances under which you would double check is if you want to be extra sure of a patient's intraocular eye pressure, correct?
MR. WHITE: Object to the form. I don't think that's what he said.
A. That's not what I said.
Q. I didn't say extra sure, so -- or you didn't say that.
Can you tell us again under what circumstances you would want to double check a patient's intraocular eye pressure?
A. One, if the reading on the initial test was questionable; and two, if they have any other signs that would make you extra concerned about that.
Q. And what type of other signs would you be

Page 72

concerned -- thinking of when you said that?
A. There would be a lot of them. A lot of signs.
Q. All right. What are the signs and symptoms of glaucoma?
A. The optic nerve where the damage occurs, you can look back there, and it may be that you can see where there's some apparent damage that you want to spend a little extra time working up. If there's a strong family history of glaucoma and you want to be extra careful. Things like that.
Q. What about seeing halos around lights? Is that a sign or symptom of glaucoma?
A. It can be. It's more often something else.
Q. Okay. What else?
A. Refractive error, cataracts, a scar on their cornea. A lot of other reasons for it besides that.
Q. Have you ever had -- Okay. Well, let me ask you. You said that it can be a sign

Page 73

and symptom of glaucoma, correct?
A. Uh-huh (positive response).
Q. Is that a yes?
A. I don't see that very much. It can be.
Q. It can be. All right. So you've stated glaucoma is a serious eye disease that can cause blindness, correct?
A. Correct.
Q. Okay. So is glaucoma something that you would want to rule out for a patient presenting with seeing halos around lights?
A. Correct.
Q. And would ruling out glaucoma involve doing more than one method of tonometry?
A. It would depend on the reading that I got on the first type. It would depend on the appearance of the optic nerve head. It would depend on whether they have other problems like a cataract or corneal scarring or other problems. How open their anterior chamber angle is. That's not something that you could say for

Page 74

everybody.
Q. Okay. If a patient presented with seeing halos around lights and pain, headaches, what would you be concerned with?
A. I don't think you could tell -- you couldn't say anything that -- the same shoe doesn't fit everybody. You can't say what you would do without having an individual there with more input, information than what you're giving me.
Q. And the way you get more input and information is to conduct testing; is that correct?
A. That's correct.
Q. Okay.
A. And ask questions.
Q. Under what circumstances would you refer a patient like that to an ophthalmologist?
A. If there were enough findings that were positive that that patient might have glaucoma, then I would refer them to an ophthalmologist.
Q. Have you ever referred a patient to an

Page 75

ophthalmologist?
A. Just every day, yes.
Q. Okay. And that's because you want to prevent serious eye problems; is that correct?
A. That's correct.
Q. And that's because you recognize that while you are an individual, as you testified earlier, trained to examine eyes, you understand that there are things that an ophthalmologist is trained to do that you are not qualified or trained to do; is that correct?
A. That's correct.
Q. Is there any treatment for glaucoma that an ophthalmologist is able to providea patient that you are not able to provide a patient?
A. Yes.
Q. Okay. Tell me about that.
A. Any surgical procedure that would be indicated.
Q. And what surgeries are used to correct

Page 76

glaucoma and intraocular pressure?
MR. WHITE: Object to the form. You're asking about what an ophthalmologist does, and I don't know that he's qualified to answer these questions. If you're just asking him if he knows, I guess he can answer.
MR. ADAMS: Sure. You're right.
Q. Do you know?
A. I have no reservation about answering that, and it would not be any one thing for any one patient. It would depend on the particular patient.
Q. Okay. But do you agree that surgery is sometimes necessary to correct glaucoma?
A. Yes.
Q. Okay. Where it says tonometry or other appropriate glaucoma testing, what other testing is appropriate to detect glaucoma?
A. Probably -- well, there's several mainstays on that. Okay. One is the pressure in your eye, okay, and looking at the optic

Page 77

nerve as we've already talked about. A family history. Their age. Their ethnicity. All of these are risk factors that you have to take into account when you're trying to determine if they have glaucoma or not.
Q. Okay. But as far as tests go, is there any test in addition to tonometry that you find -- you would believe would be appropriate to use in determining glaucoma?
A. Okay. Like I said, you do the ophthalmoscopy where you look with the microscope, and it makes their optic nerve look larger and you look for any signs of damage that might occur from them having glaucoma. You also look for any kind of problems in the anterior segment, in the front part of your eye that would be contributing to the problem if there's some anatomical problem there. Visual field is the test that you use to check for peripheral vision loss secondary to nerve damage that you get with glaucoma. You

Page 78

know, there's several,-- a lot of tests that can be done.
Q. Okay.
A. Depends on the individual patient.
Q. And what would you use to examine the angle of the eye?
A. You can use the slit lamp, you can use the gonio lens with the slit lamp, and they now have an instrument that is just coming out called an optical coherence tomography, which is a digital scanning type of thing that can take pictures of that.
Q. Okay. Which works better for examining the angle of the eye, the slit lamp or the gonioscopy?
A. The gonioscopy is done as a second procedure to the other if you see a problem on the first one.
Q. Okay. Would you use the gonioscopy to be -- to satisfy yourself that the patient did not have angle closure glaucoma?
A. If he has angle closure glaucoma, it will show up on the first test.

Page 79

Q. On the slit lamp?
A. Uh-huh (positive response).
Q. Okay.
A. And then you would also do the gonioscopy after that, too.
Q. Whether or not it showedup on the --
A. No.
Q. -- slit lamp? Okay.
Well, if a patient presented with symptoms of headaches and seeing halos around lights, what type of glaucoma would you be concerned that the patient might have, if any?
A. That would not be the first thing I would look for if they came in with halos.
Q. What's the first thing you would look for?
A. The list that we went over before.
Q. The refractive error?
A. Refractive error, corneal scarring, cataracts, retinal problems in the macula, you know, and then the other would be the -- the glaucoma would be on down on the list as far as frequency of occurrence.

Page 80

Q. And you testified earlier that you -- but you would want to satisfy yourself that it wasn't glaucoma, correct?
A. I'm going to test for glaucoma in that patient.
Q. Okay. Are you familiar with any literature on the treatment and diagnosis of eye disease that says that the puff test tonometry is not as reliable as Goldmann tonometry?
A. I have read articles that stated that and others that stated that was not true.
Q. Okay. And as you sit here today, are you aware of what the prevailing medical opinion is with respect to whether the puff test is better or whether the Goldmann tonometry is better?
A. Again, that would depend on who you ask.
Q. Well, what is your opinion?
A. I would say, like I said earlier, if there's any question about whether one or the other is not accurate, I'll do the other also on that patient.

Page 81

Q. So if I understand you right, the slit lamp exam is the primary method that you use. That's the first method you use to examine the angle of the eye, correct?
A. Correct. That's done on all patients that are getting a full eye exam.
Q. All right. And so if the gonioscopy is the second test you use, is it fair to say that you believe the gonioscopy is a more -- provides a more sophisticated view of the eye?
MR. WHITE: Object to the form.
Q. I'll rephrase that. Is it fair to say that the gonioscopy, in your view, provides a more detailed and extensive view of the eye?
A. Only of one area of the eye. Not of the whole eye.
Q. Okay. And what area is that?
A. The anterior chamber angle.
Q. Okay. And that is the angle where angle closure glaucoma occurs, correct?
A. That's correct.

Page 82

Q. Okay. Here in this rule and regulation here it says, and such other tests as are necessary under the circumstances. What other tests that we haven't talked about do you use or do you have available in your practice?
A. There are a lot of tests that are available in the practice. Can you give me -- narrow the field a little bit on that?
Q. I'm not sure I can. I'm just wondering what it might be talking about there.
A. I think you would be wise to have a more specific question, you know. I mean, are we talking about how to determine their glasses prescription or to look for, you know, retinal problems or to look for corneal problems?
Q. I'm just trying to understand how you interpret this regulation. So if you can think of any other tests that might be necessary under any circumstance, then you can just list them.
A. I really couldn't say.

Page 83

MR. WHITE: Let me object to the form of that as being over broad.
Q. Okay. Where it says -- and then the last part there says, failure to perform minimum testing -- excuse me -- failure to perform said minimum testing during a comprehensive eye exam shall constitute failure to meet standard of care.
You agree that these tests that we spent the last half hour or so talking about here are the minimum?
A. Yes.
Q. As an optometrist, do you aspire to give your patients the minimum care or do you aspire to give them something greater than the minimum?
A. Normally I would do more tests than what they've listed here on the comprehensive eye exam.
Q. Okay. And why is that?
A. To try to provide good quality of care to the patient.

Page 84

Q. Okay. And that's because you understand that patients come to you seeking your expertise for their eye problems, correct?
A. Yes.
Q. Which could include glaucoma, correct?
A. Yes.
Q. And other eye problems that could place them at risk for vision loss, correct?
A. That would be one of the reasons. That wouldn't be the only reason.
Q. Okay. Now, we had some discussion earlier about what this paragraph was, and I represent to you that it is a regulation found and said to be applicable to optometrists in Alabama found on the Alabama State Board of Optometry web site. Whether or not you agree that this is a regulation of the Alabama State Board of Optometry, again, you do agree that this is the minimum -- this lays out the minimum of what an optometrist should do, correct?
MR. WHITE: Object. I think he was asked and answered that a

Page 85

while back. I think we answered that right after we came back in after our break.
A. Depends on what the patient is coming in for.
Q. You don't disagree with any of this here, do you, that we've just read over?
MR. WHITE: Are you talking about .06 again?
MR. ADAMS: Yes, I am.
A. I think we've -- like we've already answered this before. If they're coming in for a comprehensive eye exam, which is on line four there, then all of these tests should be done.
Q. Okay. Good.
Now, as a medical professional practicing in the state of Alabama, you're aware that Alabama -- just based on statistics out there, Alabama is deemed to be a good health care state, correct?
MR. WHITE: Object to the form.
Q. Do you understand what I'm talking about?

Page 86

A. I haven't read an article on that any time lately.
Q. Okay. Well, you are aware --
You've testified that you have lived in Alabama most of your life, correct?
A. Correct.
Q. And you've testified that you've been practicing optometry for the last 27 years or so in Alabama, correct?
A. Correct.
Q. Okay. Have you ever seen any literature out there that addresses whether or not the state of Alabama enjoys -- as compared with other states in the U.S., enjoys a good quality available to patients in terms of health care, or is it below, say, what the average -- is it above average or below average in your -- based -- in your understanding?
MR. WHITE: Let me object to the question. You started off the question by asking whether he's read anything, and now

Page 87

you're asking him --
MR. ADAMS: That was a horrible question. I'll rephrase it.
Q. Do you know whether Alabama is regarded as a state where the availability of quality health care is high or low as compared to other states?
MR. WHITE: Object to the form. You can answer if you know or you understand.
A. I don't know.
Q. Okay. Is it your opinion that -- do you believe patients seeking optometric care in Alabama should expect a level of care that is on par with other states in the U.S.?
A. Yes.
Q. Okay. And as it relates to other optometry schools, are you aware of UAB's ranking?
A. Not for sure.
Q. Okay. Are you aware, is it better than average among optometry schools?
A. Yes.
Q. Okay. Would it be regarded as one of the

Page 88

best optometry schools in the country?
A. I couldn't say.
Q. All right. So it's fair to say that it's better than average?
A. Yes.
Q. And you've indicated that that is where you sometimes attend continuing education courses, correct?
A. That's correct.
Q. Okay. Do you agree that the availability of the instruction in your continuing education courses is high quality?
A. Yes.
Q. And that the instructors and folks at UAB -- That's a bad way to put that. Let me rephrase it.
Do you agree that the faculty at UAB is high quality as compared with instructors at other optometry schools around the country?
MR. WHITE: Object to the form. You can answer.
A. I couldn't say.

Page 89

Q. Okay. The continuing education that you attend at UAB, do you attend anywhere else?
A. I was --I went to New York for one last year.
Q. All right. But do you usually go to the ones at UAB?
A. I would go there more often than any other one place.
Q. All right. Who does those seminars? Is it primarily the UAB professors of optometry?
A. They speak, and they also have outside speakers come in.
Q. Okay. So as a practicing optometrist, would you agree that the most current information in the field of optometry is made available to you?
A. Yes.
Q. Okay. And that would be the most current information in the U.S., in the whole United States, is made available to you at UAB in the area of optometry?
MR. WHITE: Object to the form.
A. I really am not in a position to say. I

Page 90

haven't been to the others.
Q. Okay. But you take publications that are --
A. Uh-huh (positive response).
Q. -- national publications, correct?
A. Yes.
Q. Okay. And would you say that the information made available to you at the UAB continuing education seminars is current with those publications?
A. Yes.
Q. Okay. It's not lagging behind? It's not outdated, correct?
MR. WHITE: Object to the form.
A. Yes.
Q. And would you say that the same technology, the same optometric technology is available to you as would be available in any other state --
MR. WHITE: Object to the form.
Q. -- just based on your understanding?
A. Could you rephrase that? I'm not sure what you're asking.

Page 91

Q. Well, let me say this. I mean, if I went to an optometrist in Atlanta, would I expect him to be using any different technology, based on your knowledge, than what you offer in your practice?
A. I really couldn't say.
Q. All right. Let's just say -- are you satisfied that you're employing the most up-to-date and advanced technology for eye care that is available?
A. I think for my practice that I have good equipment.
Q. Okay. And you -- and that was true in 2004, correct?
A. Correct.
Q. And that was true in August of 2004, correct?
A. Correct.
Q. I'm just going through my outline and making sure we've covered things so we can move forward.
What are the signs and symptoms of angle closure glaucoma?

Page 92

A. Their eye is normally red, their pupil is mid dilated and not very active, their eye is usually very sore, and their pupil -- I mean, and their pressure in their eye is going to be real high, 40 or 50 as opposed to a normal of 15 to 20.
Q. Anything else?
A. Depending on how long their pressure has been up, their cornea might be a little bit cloudy. That's about all I could say that would be for sure.
Q. With angle closure glaucoma, is the pressure constantly up or can it vary?
A. That would be on a case-to-case thing. It can vary.
Q. It can vary?
A. (Witness nods head up and down.)
Q. Is that a yes?
A. If the pressure is not elevated, then they are not considered to have glaucoma at that point.
Q. But your testimony is that with angle closure glaucoma, the pressure in the eye

Page 93

can vary, correct?
A. If the angle is closed, then the pressure will be elevated.
Q. Does the angle -- with angle closure glaucoma, is the angle always closed?
A. There are different kinds of angle closure glaucoma.
Q. Okay. And what are the kinds of angle closure glaucoma?
A. You can have a primary kind, you can have a secondary kind, and the secondary kind would be due to various things.
Q. Okay. What is primary?
A. The angle just closes off because of the anatomical shape of the person's anterior chamber angle.
Q. All right. What is secondary?
A. It has several different reasons that that could happen.
Q. Okay. Can you give me some of them?
A. They could have pigmentary glaucoma where it's clogging the trabecular meshwork. They could have an angle recession where

Page 94

there's damage to the trabecular meshwork. There are others that we can look up if you want to.
Q. Well, I'm just asking you the ones you remember as you sit here right now.
A. Right.
Q. Is that all of them?
A. You can have -- anything that got inside your eye, if you had trauma to your eye, and it -- there are other iris and corneal degenerative conditions that release cells that clog up the trabecular meshwork.
Q. When is glaucoma an emergency?
A. If they came in and the pressure is very high, then I'm going to pick up the phone and call the ophthalmology office and they're going over there then.
Q. Okay. And what if they come in and they -- their history is that they're having some signs and symptoms of glaucoma, but their pressure is not high? What do you do for that kind of patient? It's not high at that visit.

Page 95

A. I couldn't say. It would depend on other things about the patient.
Q. Okay. But would you still want to run tests for glaucoma if their history --
A. Every patient that comes in gets tested for glaucoma.
Q. How is angle closure glaucoma managed?
A. That would vary from case to case. I couldn't say.
Q. All right. Well, just say primary angle closure glaucoma. How do you manage that?
A. It depends on the elevation of the pressure, and I don't manage that. That's up to the ophthalmologist.
Q. You would send that person to an ophthalmologist?
A. Yes.
Q. What about secondary angle closure glaucoma? How is that managed?
A. If the pressure is elevated, it goes to the ophthalmologist.
Q. And what if the pressure is not elevated at that particular time?

Page 96

A. And what other signs make you think that they have glaucoma at that point?
Q. Well, I'm -- that's a good question. What other signs would there be that would make you be concerned about glaucoma?
A. Well, there's a lot of them, you know. We've been through this. But if their optic nerve head shows damage, if their cornea shows damage from the pressure being too high and other things like that that you have to look for as well as just the pressure.
Q. All right. Well, you've testified earlier that with angle closure glaucoma, there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's right.
Q. All right. Would that be what's called acute angle closure glaucoma?
A. It would depend on whose book you were reading. The terms primary and secondary include that secondary are due to other

Page 97

secondary causes. Acute just means that the pressure is real high.
Q. Well, let me ask you this. What type of glaucoma are you talking about when you say that -- when you say that there is a type of glaucoma where the pressure is not constantly high, it can come and go? What type of glaucoma is that?
A. That would usually -- it kind of depends on -- like I said earlier, there's variation in the pressure anyway. But if you have something -- if you're on certain medications that might cause your pupil to be dilated versus not dilated or if you have some -- well, there's a lot of things. I just really couldn't answer that for a blanket statement.
Q. All right. You have stated, again, that there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's my understanding.
Q. Okay. If a patient presents in your office

Page 98

with signs and symptoms of glaucoma but not at that particular time elevated pressure, what do you do for that patient?
A. Again, it would depend on what other signs and symptoms there were. Okay? And the decision of when to have them back and check for this or that would depend on the other signs and symptoms if the pressure is normal.
Q. All right. Well, what if that sign and symptom --
I'm sorry. Did I cut you off?
A. Well, I'm just -- you know, I don't know if the pressure -- Well, that's all I know to say.
Q. What if the other signs and symptoms are -- include headaches and seeing halos around lights and blurry vision, but the pressure is not high at that particular time? What would you do for that patient?
A. Was this a new patient that I've never seen before?
Q. Let's take both situations. New patient

Page 99

you've never seen before.
A. Okay.
Q. What would you do?
A. I would first of all see what other things might be wrong that would cause the symptoms that you're talking about. Those are not limited to having glaucoma. In fact, that would be down the list of causes for those symptoms. It would be more common for them to have some other problems that would cause that.
If I had seen them before, then what I did or didn't do would be based on whether there was continuity from the times before, whether something was changing.
Q. Okay. Can glaucoma be managed via self-care at home?
A. That would depend on the type of glaucoma.
Q. Angle closure glaucoma. Can that be managed at home?
A. No.
Q. Not via self-care; correct?
A. I don't know of any cases where that's

Page 100

happened.
Q. Okay. If you suspect a patient of angle closure glaucoma, do you -- what do you do? If you suspect a patient of angle closure glaucoma, and you're at the end of the appointment, what next?
MR. WHITE: Object to the form. Can you define what you mean by suspect? I mean, I think he's already said what he does when they determine they have glaucoma.
Q. All right. If you are of the opinion that they may have angle closure glaucoma, and you're at the end of the appointment, what do you do?
A. I'm going to walk in and pick up the phone and call Medical Arts and ask them if he can go over there and let them look at him.
Q. Okay. And that's because you understand that angle closure glaucoma is a medical emergency, correct?
A. Correct.

Page 101

Q. Other than loss of vision and damage to the optical nerve, what other harm could come to a patient who is not treated for angle closure glaucoma?
A. Could you ask me something more specific?
Q. Yes. Let me back up and say it different. Assuming a patient has angle closure glaucoma, you agree, you've testified earlier, that if they're not treated, they could suffer nerve damage, correct?
A. Right.
Q. And they could suffer vision loss, correct?
A. Correct.
Q. Okay. And that includes not only loss of visual acuity, but loss of the vision field, correct?
A. Visual field?
Q. Yes. Thank you.
A. Yes.
Q. Okay. Now, what other medical problems or what other harm could come to that patient?
MR. WHITE: Talking about as a result of glaucoma?

Page 102

Q. As a result of angle closure glaucoma? And if you want to start out with glaucoma and move to the more specific, that's fine.
A. Say it one more time.
Q. Okay. We've already discussed and you've already stated that nerve damage and visual loss can result if angle closure glaucoma goes untreated. What else can happen to that patient that is harmful if the angle closure glaucoma is untreated?
A. I would need a more specific question than that. I'm not sure what you're asking.
Q. All right.
(Brief recess.)
MR. ADAMS: Let's go back on the record. I am going to mark what I'm going to call Plaintiff's Exhibit 2.
(Plaintiff's Exhibit 2 was marked for identification.)
Q. (Mr. Adams continuing) And Dr. Bazemore, I'm going to hand that to you and your attorney, if you'll just take a look at

Page 103

that. And I did not intend for this copy to be so hard to read. It's just the way it came out.
And obviously, you, of course, recognize that to be the human eye, correct? A diagram of the human eye?
A. Yes.
Q. Okay. Could you with this pen, please, circle for me the areas of concern, the areas that you would examine for a patient who has -- who presents with some signs and symptoms of glaucoma. With this blue pen, would you please circle the areas of the eye that you would want to examine?
MR. WHITE: Let me object to that on the grounds that -- when you say some signs and symptoms of glaucoma, I don't -- I mean, that's a pretty vague question.
A. The areas of the eye that we would want to look at if we were concerned with glaucoma would be these areas.

Page 104

MR. WHITE: And for the record, you've indicated with your finger, circling the entire eye on the diagram; is that correct?
THE WITNESS: That's correct.
Q. All right. Well, if you were concerned -- And you'll have to forgive me. I'm obviously a novice when it comes to understanding the human eye, and you are not. So I am asking you questions that may seem beneath you at times. But if you will please mark the areas of concern, the areas of the eye that you would want to examine if a patient presented with the signs and symptoms of angle closure glaucoma.
A. (Witness complies.)
Q. And you have circled the whole eye. Is there a more specific area of the eye that you would want to focus in on if you were concerned that a patient had angle closure glaucoma?
A. I don't think you could diagnose that

Page 105

unless you looked at all of these areas that I circled.
Q. Okay. Where are the angles of the eye? Just circle those for me.
A. (Witness complies.)
Q. Okay. All right. And if you want to put an A next to those circles for angle of the eye, or would you like me to do that?
A. Doesn't matter to me.
Q. I just want the record to reflect which circles you are referring to. I wouldn't want your testimony to be inaccurate --
A. (Witness complies.)
Q. -- or be misread by anyone.
(Plaintiff's Exhibit 3 was marked for identification.)
Q. I'll hand you what I'm going to mark as Plaintiff's Exhibit 3. Do you recognize what that is a diagram of?
A. Yes.
Q. Okay. What is it, please?
A. That is a picture of the anterior chamber angle, and in this particular location it's

Page 106

almost totally closed.
Q. Okay. And assuming this depicts someone's eye, what eye problem does that patient have?
A. He has a closed angle.
Q. Does everyone with a closed angle have angle closure glaucoma?
A. I would say that the risk of them having that is extremely high if they have a closed angle.
Q. Okay. All right. You can move those aside. Thank you.
All right. Let me ask you a couple of questions before we move to the next thing. Do you, Dr. Bartlett, agree that it is your obligation as a practicing optometrist to stay current with the most up-to-date information in your field in order to best serve your patients?
MR. WHITE: Object to the form. I believe you referred to him as Dr. Bartlett.
Q. I apologize. I probably did, and I didn't

Page 107

mean to do that.
Dr. Bazemore, do you agree that that is your duty?
A. I think that that would be agoal of all practitioners.
Q. Okay. And that is, in fact, what the profession requires of you, correct?
A. Say the first sentence again.
Q. Okay. I mean, you've testified earlier you have to have a certain amount of continuing education every year, correct?
A. Correct.
Q. What is the purpose of continuing education for optometrists?
A. To try to keep you abreast of the latest information available to provide eye care to the people.
Q. Okay. And it is your duty to stay abreast of such information, correct?
A. It's your responsibility.
Q. Yes. Okay. And that is in order to best serve the patients that come to you?
A. Yes.

Page 108

MR. ADAMS: Im going to mark this book as Plaintiff's Exhibit 4. I'm going to keep this book, but I'm going to give you, Matt, a copy of what I'm reading from. And that's the -- obviously, the title page.
(Plaintiff's Exhibit 4 was marked for identification.)
Q. Okay. Dr. Bazemore, I'm handing you what I've marked as Plaintiff's Exhibit 4. And I have opened this book --
First of all, take a minute to lookat that, familiarize yourself briefly with the book. And if you need to take a three-minute, off-the-record break to do that, that's fine.
MR. WHITE: Are you referring to any specific section? I know the page is opened to primary angle closure glaucoma. You want him to read that or --

Page 109

MR. ADAMS: Well, we're going to go through it in a minute. I'm just asking him to – I want him to agree --

Q. Well, take a look at the book, if you don't mind, the front page, whatever. You recognize this to be a book for optometry students, correct?

Okay. Let me back up. The title of this book is Clinical Ocular Pharmacology, Fourth Edition, correct?

A. That's correct.

Q. And it is written by a Dr. Jimmy D. Bartlett, correct?

A. There's two names on here.

Q. Right. He's one of the authors, correct?

A. Correct.

Q. And I believe he came up earlier in this deposition, and you said you recognized him as being a professor of optometry at UAB, correct?

A. That's correct.

Q. Okay. All right. And you recognize him as

Page 110

somebody who is an expert in the field of optometry?

A. I recognize him as an instructor in the field of optometry.

Q. Well, I mean, in fact, a professor of optometry.

A. Correct.

Q. Okay. Do you have an opinion as to whether he's a qualified -- as to whether he's well qualified in his field? Do you have an opinion one way or the other?

MR. WHITE: Object to the form.

A. To my knowledge, he's very capable at what he does.

Q. All right. I'd like for you to look at page 865, which is open before you, please. Under acute angle closure glaucoma, do you agree that the first sentence there -- I'm going to read it. It says, glaucoma is a true ocular urgency.

Do you see that?

A. Correct.

Q. It says, a sudden significant increase in

Page 111

IOP occurs --

And that IOP you agree means intraocular pressure, correct?

A. Yes.

Q. -- with dilation of vessels at the limbus, a steamy cornea, and a mid dilated pupil that is nonreactive to light. Symptoms of blurred vision, colored rings, halos around point sources of light, ocular pain and discomfort, nausea and often vomiting.

You agree that I read that correctly?

A. Yes.

Q. Do you agree?

A. Yes.

Q. Okay. Do you disagree that these symptoms listed are symptoms of acute angle closure glaucoma?

A. I'm sorry. Could you say that again? You kind of skipped.

Q. All right. Do you agree that this list is accurate, this list of symptoms of angle closure glaucoma --

A. Yes.

Page 112

Q. -- is accurate? Okay.

Next paragraph, it says, the clinical examination consists of history taking, biomicroscopy, gonioscopy, and tonometry.

Okay. Do you agree that the clinical examination should include those things?

A. If they already have an angle closure? Is that your question?

Q. If they have these symptoms, do you agree that the examination should include those things?

MR. WHITE: When you say these symptoms, are you talking about all of the symptoms listed above?

Q. Well, any of the symptoms listed above. If a patient presents with some -- with one or more of these symptoms, do you agree that the clinical examination should consist of history taking, biomicroscopy, gonioscopy, and tonometry?

A. Not if they don't have all of them.

Q. Okay. So it's your testimony that a

Page 113

patient would have to have all of these symptoms for the clinical examination -- for it to be required that the clinical examination include history taking, biomicroscopy, gonioscopy and tonometry?
A. Correct.
Q. Okay. Let's look at the next page, if you would, page 866. I'd like you to look at the second full sentence on that page. Do you see where it says there, is often a history of mild attacks?
A. Second -- oh, okay. You're starting down here.
That would be what he has in the book.
Q. Okay. Do you agree that a history of mild attacks can accompany someone who has acute angle closure glaucoma?
A. Often is sort of a wide-open word. My experiences with the angle closures that I have dealt with are that they are an acute problem that they come in the office with, and that's not usually -- prior history is not usually positive.

Page 114

Q. Okay. But do you agree it is possible that they could come into the office without the symptoms at that moment, but give a history of mild attacks, and that that -- that that history would necessitate you testing for acute angle closure glaucoma?
A. I can't answer that the way you're putting it.
Q. Okay. Well, let's see --
A. There are more specifics to the case.
Q. Let's see if I can do better. Do you agree that just because someone doesn't have high intraocular pressure as they sit under an exam at your office, that does not necessarily mean that they do not have angle closure glaucoma?
A. Again, that would be a case-by-case thing. You couldn't make a blanket statement about it.
Q. Is it possible?
A. It's possible, yes.
Q. And even though somebody doesn't have high intraocular pressure at the time they sit

Page 115

for an exam in your office, that does not mean that you shouldn't rule out the possibility of angle closure glaucoma through other testing, correct?
A. Angle closure glaucoma is ruled out on every patient that comes in for an exam, whether they have symptoms of it or not.
Q. Okay. And that is because angle closure glaucoma can result in blindness, correct?
MR. WHITE: Object to the form. Asked and answered.
Q. Is that correct?
A. I'm sorry. What? What was the question?
Q. That's fine. He's right. You have already affirmatively answered that.
All right. Let's look at page 869. All right. You see the section there that says, subacute and chronic angle closure glaucoma. You see that section?
A. Yes.
Q. It says, diagnosis. Okay. And I'm just going to read part of that first paragraph: A subacute angle closure attack

Page 116

requires prompt diagnosis and appropriate management in part to avoid a possible acute attack in the future. The symptoms, although transient, are similar to those in acute angle closure glaucoma and include red eye, blurred vision, colored rings around lights, tearing, ocular discomfort, and headache located above the eye.
Did I read that correctly?
A. Yes.
Q. Okay. And do you agree that -- do you agree with what I just read?
MR. WHITE: Agree that you just read it correctly?
Q. Do you agree that what I just read is accurate?
A. It would apply in some instances.
Q. Okay. Let's break it down. You agree that subacute angle closure glaucoma requires prompt diagnosis, correct?
A. Hopefully, it would.
Q. You agree that it requires appropriate management, correct?

Page 117

A. Correct.
Q. You agree that if it's not managed appropriately, possible acute attacks could occur in the future, correct?
A. That's a possibility.
Q. Okay. You agree that the signs and symptoms of angle closure glaucoma include red eye? Do you agree with that? I believe you've already testified to that.
A. If the angle is closed when they come in the office, their vessels will be dilated.
Q. Okay. And that results in red eye, correct?
A. Correct.
Q. You agree that one of the symptoms of angle closure glaucoma is blurred vision, correct?
A. Yes, it can -- that could be one of the symptoms.
Q. Okay. And you agree that colored rings around lights is one of the symptoms, correct?
A. It can be the symptom of this.

Page 118

Q. All right. And another way of saying colored rings around lights is halos, correct?
A. I guess you would have to ask the patient what they meant by that to verify that.
Q. All right. Further, you agree tearing can be a symptom of angle closure glaucoma?
A. Correct.
Q. Ocular discomfort can be a symptom?
A. Yes.
Q. And headache can be a symptom?
A. Some -- yes.
Q. Okay.
A. It can be.
Q. All right. Let's move down to the third paragraph. You see where it says, the clinical examination for both conditions consists of history, biomicroscopy, gonioscopy, optic disk evaluation, tonometry, and visual field testing. Did I read that correctly?
A. Yes.
Q. Do you agree that an accurate and thorough

Page 119

taking of the patient's history is necessary to examine for angle closure glaucoma?
A. I didn't catch the first part. You said something about history.
Q. All right. Do you agree that an accurate and thorough taking of the patient's history is necessary to examine for angle closure glaucoma?
A. Yes.
Q. And you agree that the same is true of biomicroscopy?
A. That's something that should be done on every patient.
Q. Okay. So that's a yes?
A. Uh-huh (positive response).
Q. That was a yes?
A. Yes.
Q. Okay. And do you agree that gonioscopy is necessary in order to do an appropriate clinical examination for angle closure glaucoma?
A. It's one of the tests that can be done for

Page 120

that. I mentioned earlier a couple of other tests that can also be done for that.
Q. Okay. But are you prepared to say that Dr. Bartlett should not have included this in his list of necessary examinations?
A. I think that gonioscopy -- let's see how he words this. I don't even -- let's see. What's the year on this?
Q. It's 2001.
A. Seems like some of the other instruments that I mentioned to you were not even available at the time this book was printed.
Q. Okay. And do you use any of those instruments to view the angle of the eye?
A. I have a gonioscope. I don't have one of the OHT instruments.
Q. And you had a gonioscope in 2004?
A. I did.
Q. All right. Do you agree that optic disk evaluation is necessary?
A. Yes.
Q. Do you agree that tonometry is necessary?

Page 121

A. Yes.
Q. Do you believe that he is referring to puff test tonometry or to applanation or Goldmann tonometry?
MR. WHITE: Object to the form.
Q. Based on your familiarity with the accepted form and best form of tonometry, what do you think is suggested there?
MR. WHITE: Object to the form.
MR. ADAMS: He'san optometrist. He can testify.
MR. WHITE: You're asking him to read into what he's saying and guess at what his true intent was? That's ridiculous.
MR. ADAMS: No, it's not.
MR. WHITE: It's absurd is what it is.
MR. ADAMS: No. You do your homework, and you'll find out, it's not absurd.
MR. WHITE: This man didn't do his homework? That's what you're

Page 122

saying? The author of this book didn't do his homework?
MR. ADAMS: You may not understand the question. Let me rephrase it.
Q. In the most current literature, where you see the word tonometry, is that in reference to puff test or to Goldmann tonometry?
A. I really --
MR. WHITE: Object to the form.
A. I really couldn't say unless they specified on there.
Q. Okay. You agree that visual field testing is a necessary clinical exam for somebody with the symptoms of angle closure glaucoma?
A. I think that if somebody has angle closure glaucoma that I'm going to send them to the ophthalmology clinic, and they're going to discern which tests need to be run on that patient.
Q. Okay. How are you going to determine

Page 123

whether their angle is closed?
A. By looking with the slit lamp.
Q. But you testified earlier that a gonioscopy is --
A. And I was going to say, and if it appears to be narrow with the slit lamp, I'm going to do gonioscopy.
Q. Okay. And earlier I asked you did you believe that the writers of this text were wrong to state that a gonioscopy must be one of the tests, and I'm not sure I understood your answer. Is the gonioscopy a necessary test for someone having these symptoms?
A. What was the pressure?
Q. We're not talking about pressure, as I understand it. We're talking about these symptoms. If they present with these symptoms, one of these symptoms, one or more of these symptoms, is a gonioscopy required?
A. It would depend on what other things I did and what symptoms would apply to any other

Page 124

problems that I had found or did not find on that patient.
Q. Okay. So if I understand you correctly, you are -- do I understand you correctly to disagree with the writers of this text that gonioscopy must be a test performed when a patient presents with these symptoms?
MR. WHITE: Objection to the form of that. You're paraphrasing something that the book doesn't say.
A. It doesn't say that in the book.
Q. Well, actually, what it says is the clinical examination for both conditions, referring to both types of angle closure glaucoma, consist. It consists. It will include gonioscopy.
A. That's correct.
Q. And you will agree with that?
A. If they have it.
Q. If they have these symptoms.
A. No, that's not what it says.
MR. WHITE: We're going to have to

Page 125

agree to disagree over what it says.
Q. All right. Do you agree that the use of a gonioscopy better allows you to view the angle of the eye?
A. Well, what do you --
MR. WHITE: Object to the form.
A. We've covered this one before, too. I told you there were three main things. One was with the slit lamp, one was gonioscopy, and one was the OHT instrument.
Q. Of the three, which allows you to view the angle of the eye the best?
A. I would say the OHT instrument.
Q. Okay. And then what is the second best?
A. The gonioscopy.
Q. You've testified earlier that glaucoma is a serious medical condition that can result in blindness, correct?
MR. WHITE: Object to the form.
Asked and answered.
Q. You haven't changed your mind on that, have you?

Page 126

A. No.
Q. Okay. And that is something that you need as an optometrist to rule out when you see a patient who has some symptoms of glaucoma, correct? You need to rule out glaucoma, correct?
A. I need to rule out glaucoma, yes.
Q. Okay. And in order to do that, you need to view the angle of the eye, correct?
A. Not necessarily.
Q. All right. I'd like you to look at the first full paragraph in the next column. Do you see where it says, evaluation of the anterior chamber angle is best accomplished by gonioscopy? Do you see that?
A. I do.
Q. Do you agree with that?
A. Just a minute ago, we talked about the three most commonly used ways of doing that. And like I said, when the book was written, they didn't have some of the instruments available then that -- so this book is not -- it's outdated.

Page 127

Q. All right. But, now, did you have -- What did you call it, the OHD?
A. OHT. I'm not even -- that is an instrument that has only come out here in the last year or two, so I don't even know if he has one up there or not.
Q. So you didn't have an OHT in 2004?
A. No.
Q. All right. But you've already testified you had a gonioscopy in 2004?
A. Right.
Q. Okay. Do you agree with that statement, not -- Let's forget about the OHT for a moment. Between the other available methods of viewing the angle, do you agree that the gonioscopy is the better method than the slit lamp?
A. Right. Then the von Herrick screening method. Both of them require the slit lamp.
Q. Okay. All right. Next paragraph. It says, even when the anterior chamber angle is assessed as being narrow or even

Page 128

dangerously narrow, further information is often needed.
Do you agree with that?
A. I just have to have a minute to read what's there besides that one sentence, because that's not all that's involved with it.
Q. Well, take your time.
A. Okay. Now go ahead and ask me again, please.
Q. All right. When the anterior chamber is assessed as being narrow or even dangerously narrow, further information is needed, right? Do you agree with that?
A. Further information before you do what?
Q. Well, let me just ask you. If you see a very narrow angle, may not be closed but it's narrow, what do you do?
A. I am probably going to have that go to Medical Arts to see if they want to do a prophylactic laser procedure on that.
Q. And why is that?
A. Because I'm not allowed to do that procedure? Is that what you're asking?

Page 129

Q. No, sir. I'm asking, what are you concerned about that would motivate you to send them to Medical Arts?
A. That their angle didn't close off and the pressure go up and they have nerve damage.
Q. All right. Have you ever done a pressure gonioscopy?
A. Yes.
Q. All right. Is that something that was available to you in 2004?
A. Yes.
Q. Okay. All right. I'd like you to turn to page 870, please, where it says management. You see -- I'll read it: Surgical intervention should be considered for all eyes with subacute angle closure glaucoma.
Do you see that?
A. Correct.
Q. And that involves referral to an ophthalmologist, correct?
A. It also had some other stuff after that.
Q. Okay. Do you want to talk about the other

Page 130

stuff?
MR. WHITE: Well, I think his point is you can't just take one --
A. Out of context.
MR. WHITE: -- sentence and take it out of context. I mean --
MR. ADAMS: Well, I think that's a pretty straightforward sentence. No conditions in that sentence.
MR. WHITE: Well, it's under management, and it's talking about all different kinds of management. So -- I don't know what would -- I mean, I think we can agree those words are written in this book.
Q. All right. Do you agree that if a patient has subacute angle closure glaucoma that surgical intervention should be considered?
A. That patient would be referred to Medical Arts, and it would be up to them, not to

Page 131

me, whether they had surgery or not.
Q. Correct. So if somebody has subacute angle closure glaucoma, they should be referred to an ophthalmologist. Do you agree with that?
It's not in the book. I just said it.
A. I'm just trying to look at where you're taking this sentence out of again.
Okay. Now if you'll ask me that again, please.
Q. If a patient has subacute angle closure glaucoma, they should be referred to an ophthalmologist, correct?
A. Yes.
Q. Okay. All right.
MR. ADAMS: Do you want to take a snack break?
MR. WHITE: Yeah. What time is it?
(Brief lunch recess.)
Q. (Mr. Adams continuing) Dr. Bazemore, as far as documentation goes, can you tell me why you document the treatments given?

Page 132

A. I'm sorry. You asked why do I document?
Q. Yes.
A. So next time I'll know what I did the time before.
Q. Okay. And why is that important?
A. Well, number one, it will help me understand, if the patient is in the office with a problem, whether it's a new or an old problem; whether there have been changes since that time or not.
Q. And do you document everything or just some of what you do?
Let me back up. That's kind of a bad question.
A. You'll have to be more specific.
Q. If you perform a test or an exam, are you going to document in some way that you did that test or exam?
A. There are certain exams that you would document by not writing anything down that was a result of the test other than that you did it, and that would be that it was normal.

Page 133

Q. Okay. So any test you do, there would be some notation of some sort, some marking of some sort that that test was, in fact, performed, correct?
A. Yes, to the best of my knowledge.
Q. And is that a standard that you adhere to?
A. I attempt to.
Q. Okay. And have you ever heard of the standard for medical documentation that if it's not documented, it's not done?
MR. WHITE: Objection to form.
Q. Have you ever heard of that?
A. If so, I don't recall.
Q. Okay. But whether you've heard of that or not, you agree that if you perform a test, it is -- Well, let me back up.
Your testimony is if you perform a test, you're going to document in some way that you performed it?
A. And one method of documenting would be to not put anything down.
Q. But I thought you said that you -- explain that.

Page 134

A. There are certain tests that are on there that are done by everyone, that are done on everyone, and it may just say normal.
Q. Okay. But nonetheless, it does say something? Like I said, there's some type of demarcation on the page that it was done, correct?
A. Is there some specific question about this that we're trying to get to?
Q. No. I'm just asking a general question, and I'm permitted to do that.
A. Yeah. I'm just trying to understand. The testing results should be on the medical record.
Q. Okay. Thank you.
(Plaintiff's Exhibit 5 was marked for identification.)
Q. I'm going to hand you what I've marked as Plaintiff's Exhibit 5.
MR. ADAMS: These are just his treatment notes. And I actually put them together in a reverse order

Page 135

unintentionally.
MR. WHITE: I would state for the record that these -- the medical -- the first four pages seem to be fairly clear, but the pages after that are very poor copies.
MR. ADAMS: Im going to ask him what they are. Those are copies you provided, so...
MR. WHITE: If that's all the copies you've got, we'll be glad to make you better copies from the originals.
MR. ADAMS: Okay Might take you up on that. We'll just see.
Q. All right. Well, first of all, thumb through this, the first four pages, if you would, please. What do you recognize this to be?
A. The medical records from the visits, the office visits on Kyle.
Q. And you recognize -- so you recognize

Page 136

Plaintiff's Exhibit 5, at least with respect to the first four pages, to be your treatment notes, if you will, for Kyle Bengtson?
A. They are testing notes.
Q. Okay. All right. That was my next question, how do you refer to them. Okay. The testing notes. Okay.
And I would like us to just go through what we're looking at here, if you will. Now, if you'll go to the fourth page there. Like I said, I unintentionally put them in the wrong order.
The March 24th, 2000 note, is that what you're looking at?
A. Right.
Q. Okay. And you agree this is for Kyle Bengtson, correct?
A. Yes.
Q. Okay. And just, if you will, take me through what we're looking at here as far as the top line. That's just -- you're identifying Kyle Bengtson, his date of

Page 137

birth, his age, the fact that he's a male, and he's white; is that correct? That's on the left side of the page, top left; is that correct?
A. Correct.
Q. All right. And moving to the right at the top, you're identifying the date you're performing this test, correct? And then his address, phone number, and that kind of identifying information, right?
A. Yes.
Q. All right. Now, tell me what it says -- it has uncorrected habitual RX or corrected as best I can read it. What does that mean?
A. That would be the prescription that he normally wears.
Q. And on this visit, can you tell whether or not he was wearing any eyeglasses?
A. He wasn't at that time.
Q. Okay. Ordinarily would you circle uncorrected for that?
A. For?
Q. For not wearing --

Page 138

A. For the fact that he doesn't wear glasses?
Q. Right.
A. That doesn't have anything to do with that.
Q. What does uncorrected mean?
A. That has to do with his distance acuity, and in that case it would be without a correction.
Q. I see. Okay. Thank you.
And the VA stands for visual acuity; is that right?
A. Correct.
Q. The OD stands for right eye; is that correct?
A. Yes.
Q. And what do you have there? 60-1? Is that what that is?
A. That's correct. 20/60, and he missed one letter on that line.
Q. Okay. And what does 20/60 mean?
A. That's the line of a certain size on the chart.
Q. Yeah, but what does 20/60 represent? That means he sees at -- Explain 20/60 in

Page 139

layman's terms, if you will.
A. Okay. 20/60 means that in order for him to be able to see that with his right eye, it needs to be three times as big as it would be if it was 20/20 vision in that eye.
Q. Okay. And then moving on down, the next one is what? OS?
A. OS is the left eye.
Q. Okay. And that was 20/50, and he missed one letter; is that correct?
A. Correct.
Q. Okay. And you have the word none in there. What does that mean?
A. He didn't have a habitual RX.
Q. Okay. At this time, based on what you've seen at the top here, just doing the visual acuity test, does he need glasses at this point or can you tell yet?
A. I couldn't tell yet.
Q. Okay. And then where it says history --
HX stands for history, correct?
A. Correct.
Q. All right. And last exam date, what did

Page 140

you write there?
A. Never had one.
Q. Okay. And then reason for visit. Can you interpret those, what you've written there?
A. Routine exam. Having problems seeing far away.
Q. And then below that, is that a CC?
A. Correct. Chief complaint.
Q. And what have you written there?
A. Decreased distance vision noticed last several weeks. Near vision is okay.
Q. Okay. And then to the right of there, you didn't mark anything because he's not on any medications or drug allergies?
A. Actually, at this visit, he would have filled out a sheet like this.
Q. Okay.
MR. WHITE: And you're pointing to the fifth page in that document which is marked Plaintiff's Exhibit 5.
Q. Okay. And so you know the answers to those questions because of the history, the

Page 141

written history questions he would have filled out; is that right?
A. Correct.
Q. Okay. And then the next line, what does that say? Looks like cover --
A. Cover test.
Q. Okay. What is a cover test?
A. It's a muscle balance test to see how well he uses his eyes together. The circle at the top is without correction. And ortho/ortho would be normal for distance and for near, if he's looking far away or looking up close.
Q. All right. So how do you do the cover test?
A. There's a little cover paddle, what we call a cover paddle that we use. You block one eye and then block the other eye and then do some other things to ascertain how well he uses his eyes together.
Q. Okay. Under that, what is that?
A. Vergences is a test where you use some prism to see -- if he does have a defect on

Page 142

the cover test, it helps you tell how well he compensates for that on his own.
Q. Okay. But his cover test was normal, so you didn't do that, right?
A. That's correct.
Q. What's the next thing?
A. External.
Q. Okay. And what does that say?
A. Within normal limits both eyes.
Q. Okay. And what is the external?
A. You're looking at the outside part of his eye on the lids and lashes and also at the front surface of the eye.
Q. All right. What's the next thing down there?
A. Versions. That has to do with how well you can move your eyes in all directions.
Q. Okay.
A. And it was full, which means they can move in all directions.
Q. And what is that next line?
A. Near point of convergence, which has to do with how far in you can turn your eyes when

Page 143

you look up close. That's six centimeters.
Q. And is that normal?
A. Yes, that would be normal.
Q. All right. And then pupils, what do you have there?
A. Pupils equally reactive to light and accommodation. And the other says negative MG, which stands for Marcus Gunn, which is a pupillary defect if you have optic nerve damage. And it was normal.
Q. Okay. And then we have -- explain the next -- actually, there's a mark over in the right -- on the right side of the page. What does that mean?
A. That has to do with something else. That's plus a half, which means that with the lenses that he had, he read 20/20 right under there, that -- the lenses that were obtained through the testing procedures. And the plus a half means that if you changed the lens by that much that it made it blurry.
Q. Okay.

Page 144

A. It's just to help assure the accuracy of the reading that you got.
Q. All right. Under that, you have right eye, left eye again, and looks like some visual acuity numbers. Can you interpret all of that?
A. Right here, the first part is clear in both eyes. What that does is there's an instrument called a retinoscope, and it shoots light through your pupil, and you can see the reflex in your pupil. If there are any defects in the media of the eye as you go through your cornea and your lens and everything, then this would not be clear. It would be hazy or fuzzy. So his was clear in both eyes. The next part where it says subjective is the reading that was obtained as far as doing the tests for glasses prescription.
Q. Okay. And then under visual acuity, what is that?
A. 20/20 right eye and left eye.
Q. Okay. So with these prescriptions, he's

Page 145

now at 20/20; is that right?
A. That's correct.
Q. And then what are the other -- the next line down, what does that stand for? What is that?
MR. WHITE: Talking about color vision?
A. Color vision, he missed zero with both eyes.
Q. I'm sorry. I'm still up just below the left eye thing. It's like -- my copy is bad. Looks like myopic perhaps? Right under where you've written clear. Oh, your copy is much better. Yeah. Myopic, biopic. Is that what that says? Right here.
A. No, that's a testing procedure that you use to determine their glasses prescription.
Q. Okay. And you didn't have to do that test in this case; is that correct?
A. We did it, but it's incorporated into these findings up here.
Q. I see. Okay. Across from those words,

Page 146

what do we have there? Looks like --
MR. WHITE: MA? No.
Q. What is that?
MR. WHITE: NHA. What is that, doctor?
A. PHA. Again, it's another -- it's another -- PHA stands for pinhole acuity. You use that sometimes if their vision is not corrected well with lenses to see if they can see any better through a little pinhole, or whether there's some other problem that's limiting the vision.
Q. What is NHA?
A. Near.
Q. All right. On down from there, what's the next line? What does that say?
A. Show me where you're talking about.
Stereopsis. It's a depth perception test.
Q. Okay. And was it not necessary to do that on him --
A. It wasn't done.
Q. Okay. And then going over to the right,

Page 147

looks like MISC. What is that? What does all that stand for?
A. This is -- the C-FTFC part there is confrontation full to finger count. That's a peripheral vision screening. And the right eye and the left eye, all the quadrants were normal.
Q. Okay. And then color vision?
A. No misses on that. That's with both eyes.
Q. Okay. And then under that, what is that word?
A. The one to the left-hand side of the page is keratometry.
Q. Okay.
A. It measures the curvature on the front surface of your eye.
Q. Okay. And what are you finding there for his right eye and his left eye?
A. It's within normal range.
Q. Okay. And what is this marking over to the right that you have? What does that mean?
A. Volk 90 and IO mean -- that means that we looked in the back of his eye with a Volk

Page 148

90 lens and with an indirect ophthalmoscope.
Q. And why would you do that?
A. That's done on everybody.
Q. And what are you testing for?
A. You're looking anywhere from the front surface of their eye all the way to the back, and you look and see if you see any problems.
Q. Okay. All right. The SLE there. That's slit lamp exam?
A. Right.
Q. And what have you written there?
A. That has one to one half grade three angle in both eyes, and WNL would be within normal limits for the eyes and the lids. And then it says OU out to the side, which is both eyes.
Q. Okay. And then to the right of there, what is that?
A. That has to do with retinal findings. It has to do with cup-disk ratio and the fovea and the general retinal area and the

Page 149

arterial/venous ratio, various things
Q. Okay. What are you testing for there?
A. Any type of abnormality that you might see.
Q. Okay. So what does that test consist of?
A. You're looking inside their eyes with the -- those two lenses that were on the left-hand side of that entry.
Q. Okay.
A. You look -- the Volk 90, you look with the slit lamp. The other one you look with a hand-held instrument, the indirect ophthalmoscope.
Q. Okay. Below that it says tonometry; is that correct?
A. Correct.
Q. NCT. Is that the puff test?
A. That's noncontact tonometry.
Q. Is that what a puff test is?
A. Yes.
Q. And what does that say next to that?
A. At three o'clock p.m., and then the readings were 17 for the right and 16 for the left.

Page 150

Q. Okay. And what does that say to the right up there?
A. A for assessment, compound myopic astigmat both eyes.
Q. And then the plan for Kyle was what?
A. RX glasses for distance vision only. Recheck in a year.
Q. Okay. And is this the right eye prescription and the left eye prescription?
A. Right's on the top.
Q. Okay. And you've signed it; is that correct?
A. Correct.
Q. And has anybody else signed it there?
A. No.
Q. Looks like somebody's signature and then your signature perhaps.
A. Where is that?
Q. Well, I don't know. What's that?
A. Recheck one year.
Q. I see. Okay.
All right. Let's go to the next one.
You agree that the next page up is October

Page 151

the 2nd, 2001 for Kyle Bengtson, correct?
A. Correct.
Q. All right. And then the visual acuity is apparently –
Under visual acuity, are you testing him corrected or uncorrected at this point?
A. It's on the uncorrected side there.
Q. I see. Where would it be -- okay. The habitual RX, that means he wears glasses, right?
A. Right. That would be the pair of glasses that he got on the previous office visit.
Q. Okay. So he's being tested with his glasses on?
A. No. That entry to the left-hand side of that area is without them.
Q. I see. Okay.
A. If it was with them, it would be to the right-hand side of that line.
Q. Okay. So how has his vision changed since March of 2000?
A. It's very close.
Q. Is it better or worse --

Page 152

MR. WHITE: Just for the record, you're saying from March of 2000 until October of -- October 2nd, '01?
MR. ADAMS: Right.
MR. WHITE: Okay.
Q. You said it's very close?
A. Uh-huh (positive response).
Q. Okay. Is it better or worse?
A. It's about the same.
Q. All right. So you've got 20/60 in the right eye, correct?
A. Correct.
Q. The SPH there, what does that mean?
A. Sphere.
Q. And you've got a negative .50? What does that mean?
A. That's the strength of the lens as far as the spherical part.
Q. All right. And the CYL, what does that stand for?
A. That's cylinder.
Q. Okay.

Page 153

A. That has to do with the correction for astigmatism.
Q. Okay. And then axis, what does that mean?
A. That has to do with the correction for astigmatism also.
Q. All right. And what is axis 95? What does that mean?
A. It has to do with the orientation of the difference in the power for the correction for astigmatism.
Q. So going back to the March exam, how would you describe Kyle's eye health at the time he was at your office?
MR. WHITE: Talking about the March 2000?
MR. ADAMS: Yes.
Q. In March 2000.
A. There were no abnormalities found.
Q. Okay. So he's basically got healthy eyes at this point?
A. Uh-huh (positive response).
Q. With a need for a mild prescription; is that fair?

Page 154

A. His distance vision was a little bit off.
Q. Okay. All right. And then you've indicated that in October of 2001 that it's about the same, correct?
MR. WHITE: Talking about his vision? You say it.
MR. ADAMS: Well, I'm --
Q. Yeah. I'm talking about his vision generally.
A. His glasses prescription?
Q. Yes. Just --
A. It's very similar.
Q. Okay. The reason he says -- what does that say there? Reason -- I'm not quite sure...
A. Reason, wants contact lenses. That's why he was there. And then it says, never worn right above that.
Q. And what do you take that to mean, the never worn?
A. He's never worn contact lenses.
Q. All right. And then on history, just interpret everything you've written there, please.

Page 155

A. No general health problems. He's not on any medicine. He's not allergic to any drugs that he's aware of, and there's no ocular history of him having any eye problems or any diseases or blindness in the family.
Q. All right. And then where it says under last eye exam, it says -- looks like last -- what does that say? Check? Can you interpret --
A. Last checkup. That's what that means.
Q. All right. And what does it say?
A. 3/24/2000 was the date for the last checkup.
Q. All right. Last checkup, and then it says what, new glasses?
A. New glasses then. Wears as needed, PRN.
Q. Okay. Chief complaint is what?
A. Wants contacts. Never worn.
Q. All right. Cover test is --
A. Normal.
Q. -- normal again. And then the EXT, what does that say there?

Page 156

A. That was the external part of your eye.
Q. Okay. And how --
A. Normal.
Q. Okay. And then versions, what does that say?
A. Full in all fields of gaze.
Q. NPC?
A. Near point of convergence, it was six centimeters.
Q. Same as before?
A. I think the last time it was six or seven. Yeah, six.
Q. Pupils?
A. Were normal.
Q. And then under that is ACC? Is that what that is?
A. Accommodation was not attempted. It has to do with his ability to shift his focus to up close, but he wasn't having any problems with that.
Q. Okay. And then describe what this means, the right eye and the left eye, where you have the negative 25. Explain all that.

Page 157

What is all that?
A. He's nearsighted, and he has a small amount of astigmatism. It's about one point different than it was the time before.
Q. Okay.
A. Or in the case of the left eye, it's only a half a point different.
Q. And what kind of visual loss is that, one point, a half a point?
A. Extremely small. Smallest thing that we can measure.
Q. Okay. So he still has pretty good eye health, correct?
A. Correct.
Q. In fact, probably you would say good eye health?
A. Yes.
Q. Okay. Now, above VA, it looks like TSO or something? What is that?
A. That's plus a half.
Q. Okay. Looks like plus point 50?
A. That was a test to make sure that the lens that you had arrived at on the prescription

Page 158

was accurate.
Q. And then these monocular, binocular, did you do any tests related to that?
A. No.
Q. All right. And then below that, the stereopsis. How do you say that?
A. That's correct.
Q. Did you do that?
A. No.
Q. Okay. Color vision, he had no misses; is that correct?
A. Correct.
Q. And then what is this confrontation thing over there? What was that?
A. That was the visual field screening, and it was all normal.
Q. Okay. What does that say? Right eye what?
A. Right eye full to finger count. Left eye full to finger count in all quadrants.
Q. Okay. And then the --
A. Keratometry.
Q. Yeah. What is that?
A. That measures the front surface of your

Page 159

eye.
Q. And what is that like at this point?
A. It's normal.
Q. All right. The slit lamp exam, what is that? I know what it is, but what do you have marked there?
A. Anterior chamber angle was one to one and a half, which is about a grade three, and everything else was fine.
Q. All right. A grade three, what do you mean by that?
A. That deals with how open your anterior chamber angle is.
Q. Is that regarded as being -- what -- in terms of -- how narrow is that?
A. Four is the most open, and one -- well, zero would be closed.
Q. Okay. So is this angle more narrow than it was in his previous visit?
A. It's about the same.
Q. Okay. So four is the most open, zero is closed?
A. That's correct.

Page 160

Q. So just what is the norm?
A. The vast majority of the people are going to be in the three to four range.
Q. Okay. So his angle on both visits was narrower than what is typical?
A. No.
MR. WHITE: Object to the form.
Q. Well, you said earlier zero was closed, correct?
A. Correct.
Q. Four is the most open?
A. Correct.
Q. Okay. So he is closer to having a closed angle than he is to having an open angle?
A. Three is closer to four than to zero.
Q. But he's a one and a half, isn't he?
A. No. It's a grade three. Right by there --
Q. I'm sorry. Okay. I misunderstood. The one and a half was throwing me off. Okay. So he's a grade three?
A. Uh-huh (positive response).
Q. All right. And what do you have written under there?

Page 161

A. Where are we?
Q. Still at the slit lamp exam.
A. Within normal limits for eyes and lids, both eyes.
Q. Okay. And then OPH. What does that say?
A. E3 .35 .35 spontaneous venous pulsation present in both eyes, AV 3 to 5 and fovea and general retinal area clear in both eyes.
Q. Okay. Interpret that for me. What does that mean?
A. That means that when we looked inside his eye, everything looked normal.
Q. Okay. On tonometry, it says, NCT at 3:50 p.m.
A. Right.
Q. And then you have -- what is the reading there?
A. The first reading on the noncontact tonometer was 28 and 24. And that was high, so I was concerned about it. And I had a note on here when we went back and did that that he was squeezing his lids

Page 162

shut, which sometimes happens with that because they anticipate the puff of air coming. And if they're squeezing their other eye shut, the muscles squeeze on your eye and it elevates the pressure. So we went back and did it with a Goldmann tonometer there, and it was much lower.
Q. All right. But that is still higher than it was?
A. Little bit. It goes up and down during the day. If I took it at eight and at four, it wouldn't be the same thing.
Q. What do you have written under there?
A. Myopia. Wants contact lenses.
Q. Okay. And then the plan is what?
A. New contact lens fit with the brand and parameters of the contacts. Wear daily wear, eight, 12, 16 hours. OptiFree is the care kit that we gave him a sample to use to take care of the lenses. Recheck in one week.
Q. Okay. Why are you rechecking in one week?
A. We recheck all of the new contact lens fits

Page 163

to be sure they're not causing a problem.
Q. Okay.
A. And that they're performing properly.
Q. Okay. Now, is this something that you would refer back to on a subsequent visit?
A. Refer back, like the next time he comes, am I going to look back at this?
Q. Right.
A. Yes.
Q. All right. Let's look at the September 27th, 2003 visit.
A. Okay.
Q. And his visual acuity, is it better or worse?
A. It's very close to the same thing.
Q. All right. And just interpret those markings for us, please. Just --
MR. WHITE: Talking about under VA?
MR. ADAMS: Yes
Q. Tell us what you've written there.
A. Twenty -- this, again, could be uncorrected. Distance vision 20/50 in the

Page 164

right, 20/40 in the left.
Q. And then what do you have there to the right?
A. That's the lenses that he was wearing from the previous exam. That's the prescription.
Q. What does that say?
A. UltraFlex daily wear, eight, six, 14, O minus one, minus 75.
Q. And his last eye exam, what does that say?
A. Eyes checked 10/01.
Q. What does it say after that, please?
A. New contact lenses then. Wears part time. Chief complaint, checkup and update contact lenses.
Q. All right. And then general health, what is that?
A. WNL, within normal limits.
Q. Medications?
A. None.
Q. Drug allergies?
A. No drug allergies.
Q. Ocular history?

Page 165

A. Negative personal and familial.
Q. And the cover test, what is that?
A. Normal. Zero zero.
Q. Okay. And then external, what does that say?
A. Within normal limits, both eyes.
Q. Versions?
A. Full. That's normal.
Q. All right. NPC?
A. Six centimeters.
Q. All right. Pupils?
A. Equally reactive to light and accommodation, negative Marcus Gunn.
Q. Okay. And then the right eye and the left eye on whatever -- the rest of what this is, what is that?
A. In the middle of the page?
Q. Yes.
A. That's the determination of their prescription for optical correction.
Q. Okay. We have this little marking -- Okay. That's, again, plus one half?
A. Plus .5. Plus 50.

Page 166

Q. What does that mean, again?
A. That means that when we got through with the subjective and we held the plus 50 up there, it made it blurry, so we knew they're not too strong.
Q. Okay. And then monocular and binocular. What was that?
A. That just has to do with some testing procedures and whether you did one or the other.
Q. Okay. And then stereopsis. What was that?
A. Depth perception test.
Q. Okay. And how did that go?
A. It wasn't performed.
Q. Okay. Why was that not performed?
A. It's not performed on the standard patient. Sometimes if they're trying to get in pilot programs or some other specialty, some of the military cases that we have have to have that done for flying helicopters and stuff.
Q. Okay. And then keratometry. What was that?

Page 167

(Brief recess.)
Q. (Mr. Adams continuing) So the keratometry, you did not perform that test; is that correct?
A. Not that visit.
Q. Okay. And why not?
A. It doesn't typically change a whole lot every time you do it. If you want to look back at the other two there, there was a very small change, and we use those for a baseline.
Q. Okay. But as far as this visit, you didn't do it, right?
A. That's correct.
Q. Okay.
A. Actually, it was done, and it was stapled onto here with the reading out of the autorefractor, but I don't know where it is. It would have been stapled onto there, onto the original.
Q. All right. Miscellaneous. What is that? Confrontation?
A. Oh, uh-huh (positive response). Yeah.

Page 168

Same thing. Full to finger count in the right eye and the left eye in all different quadrants.
Q. And then the slit lamp exam. Explain that.
A. Again, it just has to do with the screening for how open it is. Then it says, normal for the eyes and the lids in both eyes.
Q. All right. Well, what is the openness of the angle rate?
A. This time it was even a little larger than last time.
MR. WHITE: Read to him what it is.
A. One to three quarters, grade four.
Q. Okay.
A. Angle, both eyes.
Q. And one to three quarters, what is that?
A. That has to do with the way that things are measured with the von Herrick method of examining that with the slit lamp.
Q. Okay.
A. And...

Page 169

Q. All right. And then the OPH, what are you --
A. Ophthalmoscopy.
Q. What do you have written there?
A. Point 35 C/D ratio for both eyes, spontaneous venous pulse, arterio/venous ratio three to five on the retina, fovea and general retinal area clear in both eyes.
Q. Okay. And then under that, it looks like it says --
A. Replacement daily wear soft contact lenses and a prescription for glasses underneath there.
Q. And then the tonometry is what?
A. Twelve and 14 at 8:50 in the morning.
Q. And then the IMP, is that impression?
A. Correct.
Q. And what does that say there?
A. Myop in both eyes with astigmatism with change in the right eye.
Q. And what is the plan?
A. That's what we were talking about where --

Page 170

replace the contact lenses and put a new glasses prescription on there and then recheck in one year.
Q. Okay. And then the $47, what does that mean?
A. That was the charge for the office visit that date.
Q. Okay. And you don't have any contention that at any time he failed to pay you, correct? I mean, he always paid you as far as you know?
A. As far as I know.
Q. As far as you know. Okay.
In September of 2003, would you have had a gonioscopy in the office at that time?
A. Yes.
Q. And would you have had the capability of using a Goldmann -- using Goldmann tonometry at that time?
A. Yes.
Q. Okay. And by the way, is there anything else that is missing from the record? I

Page 171

think you said that there might have been something related to the keratometry that wasn't on here. Are you aware of any other papers or items missing from --
A. I mentioned the one I think that's in the original records that -- he did that the first time he was here.
MR. WHITE: You're pointing to the fifth document in this Plaintiff's Exhibit 5. And I think this is actually -- it's a very faded copy of that. You can faintly see his signature on this.
Q. But other than that, other than maybe a written history that is either not there or unclear, you're not aware of any other documents that would be -- have been in his optometry record in your office that are not part of that exhibit?
MR. WHITE: Object to the form. Let me just say the written history is here, and

Page 172

it is clear. Now, you have a bad copy of it here, but we'll be glad -- I said before we would be glad to make you another copy. I didn't realize that -- if you have a bad copy, we'll get you a better copy. But the original is very clear.
MR. ADAMS: That would be good.
MR. WHITE: In fact, I showed the original to your client at his deposition.
MR. ADAMS: Okay. I'm not sure I've got that with me, so I -- I'm not sure you provided it, so I'd like that. That would be good.
MR. WHITE: Okay. We provided it, because you got a copy of it. You just, apparently, got a poor copy of it.
MR. ADAMS: Okay. What I meant is

Page 173

at the deposition, I don't think I left the deposition with a copy of that exhibit.
MR. WHITE: That's fine.
MR. ADAMS: All right. Let's just press on, and then we'll talk about it.
MR. WHITE: We'll get it at the next break. I'll be glad to make you a clearer copy.
MR. ADAMS: All right.
Q. Let's go to the August 20th, 2004 office visit, please.
Under visual acuity, right eye, it looks like his vision has gotten worse; is that accurate? Am I reading that right?
A. Yes.
Q. It is accurate? Okay. It's now 20/100?
A. It has changed I thought was the question.
Q. I asked had it gotten worse.
A. Right.
Q. It has?
A. Yes.

Page 174

Q. All right. Interpret those numbers for me, please. Just tell me what all that means under visual acuity.
A. Okay. Again, uncorrected distance visual acuity is on the left-hand side of the sheet. The right eye was 20/100 and the left eye was 20/40. Then it has the correction for his last glasses prescription there, and then it has the last contact lens prescription next to it.
Q. Okay. Is there anything that you're concerned about when you see his right eye has gone from 20/50 to 20/100?
A. Well, it's obviously changed some, and we just have to find out what's caused it to do that.
Q. What could be the reasons for that?
A. Far and away the most common would be a change in his glasses prescription. He could have also had a cataract. He could have also had a corneal injury that left a scar. He could have a retinal problem. You know, a lot of things.

Page 175

Q. And could episodes of angle closure contribute to a loss of vision?
A. That would be very uncommon.
Q. Okay. I mean, but you testified several times that a closed angle, angle closure glaucoma can cause nerve damage, correct?
A. Correct.
Q. Okay. All right. So that can lead to a loss of vision?
A. Can nerve damage lead to a loss of vision? Is that what you're asking?
Q. Yes.
A. Yes.
Q. Okay. His last eye exam was -- you have September 27th, 2003, right? Is that what you've written there?
A. Uh-huh (positive response). Yes.
Q. And under chief complaint, what have you written, please?
A. We're going underneath there now?
Q. Yes.
A. Trouble with right eye. Has film over it and is worse at night. Sees halos around

Page 176

lights. And it's been that way for approximately two months with minor worsening.
Q. Okay. And then reason over here where it says --
A. Problem with right eye. And then something got blocked off on the edge. Feels like something -- feels -- has film over it.
Q. Okay. Is my copy any better?
A. There's a word right here. I can't tell what it is.
Q. Okay. Do you have any idea?
A. I would say that it's probably -- it looks like an H, and it has film, which was the word that he used that I put in parentheses on the other side.
Q. Okay. What is above the problem with right eye, where it says reason? What does that say?
A. Routine exam.
Q. All right. Now, why did you put routine exam?
A. Because it wasn't for anything other than a

Page 177

normal comprehensive eye exam.
Q. Okay. But --
A. It wasn't for a foreign body or for a red eye or for any other number of things that it could be for.
Q. How often would you say you have patients who present with seeing halos and --
A. It's fairly common.
Q. Is it? How often would you say?
A. You mean like give you a percentage of the patients who complain about that? I hear it every day, if that's what you're asking.
Q. Do you?
A. Uh-huh (positive response).
Q. But do you always write it? Do you always make a note of it?
A. I would say something about that they would have halos or fuzziness around the lights.
Q. Okay. What about the film?
A. That's just another way of expressing that it's not clear.
Q. Blurry?
A. (Witness nods head up and down.)

Page 178

Q. You would – film over it, blurred vision, that would probably fall in the same category?
A. It would all be symptoms of something that's making it not clear.
Q. Medications. What does it say there? No?
A. No, and then no known drug allergies. And then by the ocular history, negative personal and familial history.
Q. General health is good, correct?
A. Correct.
Q. All right. The cover test. What is that?
A. That's the muscle balance test. It's normal, zero and zero.
Q. And then vergences?
A. That has to do with the testing to seehow well they handle the defect if they have a defect on the cover test.
Q. Okay. External. What does that say?
A. Within normal limits for both eyes.
Q. Okay. And then versions?
A. Full.
Q. NPC?

Page 179

A. Seven centimeters.
Q. Okay. Now, the fact that it's going up, is that good or bad?
A. If we did it ten times, we might get six four and seven five and eight one. I mean, that's one millimeter. It's like this much, you know.
Q. Okay. Pupils?
A. Normal. Equally reactive to light and accommodation.
Q. Okay.
A. Negative Marcus Gunn sign, which would -- if that was positive, it would indicate nerve damage, but it was negative.
Q. And what instrument are you using to --
A. Use a pen light to check pupils, or you can use a transilluminator out of the hand equipment.
Q. Which is better?
A. They both do the same thing.
Q. Okay. Right eye. Below that, you say it's clear?
A. Clear reflex on the retinoscopy, which

Page 180

shown light through to the back of your eye.
Q. All right. And what is this? What are these numbers in the middle here?
A. That's the prescription for the glasses that he sees the best with. The left eye is exactly the same as last time, and the right eye has changed some. And the correction for astigmatism has gone up in that eye.
Q. Okay. And how is the right eye changed?
A. That was the right eye. The correction for astigmatism went up.
Q. Okay. Because the visual -- the distance -- he's more nearsighted now in his right eye, correct?
A. No -- well, one step. The major loss of vision there was the correction for astigmatism change.
Q. Okay. And then visual acuity under that, what is that?
A. To the side you mean?
Q. Yes, to the side.

Page 181

A. So the right eye was seeing 20/25 plus two, and the left eye saw 20/20 minus one, which means that with the right eye, he got two right on the 20/20 line, and on the left eye he missed one on the 20/20 line.
Q. So how has his vision changed?
A. The correction for astigmatism has gone up a good bit in the right eye.
Q. Okay. And how would you describe his overall visual health at this point?
A. Health as in pathology or --
Q. I'll tell you what. Let's just strike that. We'll come back to it.
All right. Monocular and binocular.
A. That has to do with the type of cross-cylinder you use on the phoropter.
Q. PRA and NRA. What's that?
A. Same thing.
Q. Okay. And why didn't you do that, again?
A. Positive relative accommodation has to do with the type of -- when you go through and you adjust the lenses on the refractor, and -- all of these things, the monocular

Page 182

cross cylinder and the PRA and the NRA have to do mainly with things that are done on people whose vision does not correct well.
Q. Okay. And was there any reason to do any of those?
A. I did not feel it was indicated.
Q. All right. Why not?
A. There was no reason to do it. The monocular cross cylinder is done on everybody that has a glasses prescription.
Q. But he did have a glasses prescription.
A. Yeah, that's what I'm saying. All that -- the fact that this -- this is not something, you know -- this is something that's built into the instrument. Now, if you do a refraction with trial lenses, then you have to take a cross cylinder out of the drawer and hold it up and flip it and stuff. But every time you do a subjective refraction through a phoropter, it has a monocular cross cylinder.
Q. All right. So why didn't you do it?
A. It's automatically done.

Page 183

Q. All right. Well, why isn't it documented?
A. Well, because you can't choose. You do it if you use that instrument.
Q. Okay.
A. There was not -- it's done every time they come in and they are refracted through the phoropter.
Q. I don't understand why it's not written down.
A. Because anybody that understood how the subjective was done would know that that was used as part of the instrument to check that. So any other doctor that was looking would already know that if this test was done, it was done with that.
Q. Okay. Stereopsis. Was that done?
A. No.
Q. Okay. And, again, what is that test?
A. Depth perception?
Q. Color vision. What do you have written there?
A. He didn't miss any of those.
Q. And then to the right of that, what does it

Page 184

say?
A. Confrontation test where they do finger count and check the peripheral vision, and it was normal in both eyes.
Q. All right. And then keratometry. What do you have there?
A. Well, it just has the readings and the curvature on the front of the eye there, and that's the results of the test right there.
Q. Okay. And has that changed?
A. I expect so, because the correction for astigmatism changed. Let's see. I'm looking at 3/24/2000. If you want to look back there, the right eye, there's a difference between the left-hand number and the right-hand number. It was .37 then, and now it's 1.5. On the right eye it was .5, and now it's zero. The major difference is in the right eye where there's an increase in the curvature in one meridian versus the other, which is why the correction for astigmatism changed.

Page 185

Q. All right. And what do you have written to the right of there? What is that?
A. The M one percent OD and OS?
Q. What is that?
A. That's just the drop I put in to dilate his pupils.
Q. Okay. And then the slit lamp exam. What were the findings there?
A. It's one to three quarters, which is a grade four angle. Normal eyes and lids in both eyes.
Q. And then OPH. What is that?
A. Ophthalmoscopy, and it was normal also.
Q. Okay. And what does the ophthalmoscopy measure?
A. That looks into the back surface of your eye on the retina, or that's the major thing you're doing with it.
Q. Well, tell me what those markings are. I can't read your writing, so if you can just --
A. Oh. E3, which has to do with the category of the cupping in the optic nerve, the

Page 186

cup-to-disk ratio. And then it says SVP plus, which is spontaneous venous pulsation.
Q. Spontaneous what?
A. Venous pulsation. If you do not have a spontaneous venous pulsation, you have some circulatory problems.
Q. Okay. What was his spontaneous?
A. It was fine. It was SVP plus in both eyes.
Q. It looks like a 138 there. What is that?
MR. WHITE: Where are you looking at?
Q. In front of DS.
MR. WHITE: Point three five?
A. Point three five. I'm sorry. I didn't know what you were talking about.
Q. And then under that, what do you have written?
A. Fovea and general retinal area normal in both eyes.
Q. And then to the side of that, what is that?
A. Slit lamp -- oh, you're talking about over to the right-hand side?

Page 187

Q. Yes.
A. That's OU for both eyes.
Q. All right. Okay. So the NCT, what is that? I know what --
A. The reading? 13 and 12.
Q. At 10:20 in the morning?
A. Correct.
Q. And then what is your impression there?
A. Underneath? Is that what you're --
Q. Yes.
A. Compound myopic astigmat with change in the right eye. And that's -- it looks like it's change in the best corrected visual acuity in the right eye.
Q. And then your plan, what is that?
A. Change the right lens to the subjective reading up above after a positive demo of the change, which means that the patient was shown the new lens there in the chair in the office and thought that everything looked real good with that and wanted to change to that.
Q. Okay. And then under there it says right

Page 188

eye -- what, now?
A. That's the prescription for the glasses.
Q. And then you have recheck in one year?
A. Correct.
Q. Okay. You did not do Goldmann's tonometry, correct?
A. Not that visit, no.
Q. And you didn't do gonioscopy, correct?
A. No.
Q. All right. Do you agree that blurry vision is a symptom of angle closure glaucoma?
A. It is a symptom of angle closure glaucoma, but angle closure glaucoma is far and away not the most common source of blurry vision.
Q. Okay. And what would be more common?
A. A change in the refractive error, cataracts, corneal scars, a lot of other things.
Q. Tell me some more other things.
A. Retinal problems, central serous retinopathy, retinal detachments. You could have optic neuritis, which is

Page 189

something that – another incident that causes damage to the optic nerve. You could have hyphema, which is the leakage of a blood vessel in the back of your eye that can be secondary to diabetes or a list of other general health problems.

You want me to keep going?

Q. Yeah.

A. Okay. You could have what's known as iritis, which is an inflammatory problem.

You know, I'd have to have something to write with and write all these down so I'm not repeating myself on all of them.

Q. You testified earlier you agree that seeing halos around lights is a symptom of angle closure glaucoma, correct?

A. Yes.

Q. Okay. The two of those coupled together –

A. I'm sorry. Which two are we talking about?

Q. The blurry vision or film over the eye together with the halos around lights. Would you agree that that should cause some concern for an optometrist that Kyle may

Page 190

have -- or that this patient, a patient presenting with this could have angle closure glaucoma?

A. That would be a possibility, and it would be a very low chance.

Q. But because it's a possibility and because glaucoma is so dangerous and can result in blindness, it is something you would want to eliminate?

A. Right.

Q. Okay. And therefore, you would want to conduct a thorough examination of the patient's angles, correct?

A. That is -- that does not define him as having glaucoma or not. That only defines the appearance of the angle. There were tests done: Measuring the pressure in his eye, looking at the optic nerve, checking the pupillary actions, doing a screening for angle closure with the slit lamp. All of those were testing to see if he showed any other signs or symptoms of glaucoma.

Q. Okay. But I believe your testimony earlier

Page 191

was that the gonioscopy presents a better view of the angle; is that correct?

A. Right. That's correct.

Q. Okay. Why did you not use the gonioscopy to get the best possible view of the angle?

A. Because there was no indication to do that. All the other findings to rule out glaucoma were okay.

Q. What other findings?

A. I just went through them. It had to do with the pressure in his eye. It had to do with the appearance of his optic nerve. It has to do with the clarity of his cornea. Has to do with -- we've already screened to see if his angle was open with the slit lamp exam, and all of those findings were normal.

Q. Are you aware as to whether the NCT tonometry was the preferred tonometry test at the time of this visit?

MR. WHITE: Object to the form.

A. Could you rephrase that another way for me?

Q. Well, let's kind of back up. On one of his

Page 192

prior visits, the October 2001 visit, you had had a problem with the NCT tonometry, correct?

MR. WHITE: Object to the form. I don't believe that's what he testified to.

Q. Well, you had had to do another type of tonometry, correct?

A. I didn't have to. I wanted to.

Q. And you testified you wanted to because you believed Kyle was squinting his eyes or squeezing his lids together?

A. That's what was written on the chart, yes.

Q. And is that sometimes a problem with the NCT tonometry?

A. Yes.

Q. And the NCT tonometry is a less accurate test because patients often do that, correct?

A. They don't often do it.

Q. Well, they sometimes do it, right?

A. Uh-huh (positive response).

Q. Yes?

Page 193

A. Yes.
Q. Okay. And this October 2nd, 2001 testing note or whatever you called it, it was available to you in Kyle's chart on August the 20th, 2004 when Kyle came in, correct?
A. I'm sorry. Say that again?
Q. Yes. The October the 2nd, 2001 testing note, it was part of Kyle's chart when he came in in August of 2004?
A. Correct.
Q. Okay. And do you review the full chart when the patient comes in or just the previous visit?
A. That would vary from patient to patient, depending on what problems they had and how many times they had been in to the office.
Q. Okay. Well, in this circumstance, do you know if you looked back?
A. Since he had only been --
Do I remember if I looked back or not?
Q. Right.
A. No, I don't recall.
Q. All right. Well, let's just say, since you

Page 194

don't recall, I mean, a patient presenting with a significant loss of visual acuity in his right eye.
Do you agree that he had had a significant loss of visual acuity in his right eye?
A. In his uncorrected visual acuity.
Q. Yes. Since the prior visit, he had gone from 20/50 in the right eye to 20/100.
A. Correct.
Q. Would you call that a significant loss of visual acuity?
A. I would call it a significant loss of uncorrected visual acuity. His corrected visual acuity was very close to the same.
Q. Okay. And then he was present -- his history and his chief complaint was blurry vision or film over his eyes -- or his eye, his right eye, halos around lights, and that it had been getting worse over the past two months, correct?
A. Correct.
Q. Okay. Would those things taken together

Page 195

cause you in a normal circumstance to review the patient's entire history?
A. I would say that the chances of me looking at all of the exams that he had been in before, with there only being three others, that I probably looked at all of them.
Q. Okay.
A. If it had been 15 years and there was one from that far back, I doubt I would have looked at it.
Q. Okay. Well, knowing that he had at least two of the signs and symptoms of glaucoma, and knowing that he had problems with the puff test tonometry on a prior visit, why did you not do a Goldmann's tonometry test to measure his intraocular pressure in his right eye?
MR. WHITE: Object to the form.
A. There was no indication to do that because the pressure was normal, and it had been consistent over the four visits.
Q. But in at least one of his four visits, the puff test reading had been in error,

Page 196

correct?
A. Correct, and it was verified by doing it another way.
Q. Okay. So if he had problems with the puff test previously, why did you continue to use it?
A. On the LED display on the instrument itself, it has an asterisk that comes up if the reading is questionable. And if it doesn't come up, then I take it as correct. But if it's off like that, I just go ahead and check it again with the Goldmann.
Q. Okay. You acknowledged and agreed earlier that angle closure glaucoma is a medical emergency, didn't you?
MR. WHITE: Object to the form.
Asked and answered.
Q. Your opinion hasn't changed on that, right?
A. Unh-unh (negative response).
Q. That's a no?
A. No.
Q. Okay. And in that circumstance, when

Page 197

presented with a potential emergency, do you find it more necessary to rely on your expertise and training as an optometrist or on the functioning of your equipment?

MR. WHITE: Object to the form.

A. I think you would have to ask me a more specific question than that.

Q. Okay. Do you always rely on your equipment? I mean, do you ever find it necessary to use your professional judgment?

A. Just on every patient.

Q. And sometimes equipment can make a mistake, correct?

A. Sure.

Q. I mean, you know, equipment doesn't always work as it should, right?

A. Right.

Q. Okay. And you are a licensed optometrist with a therapeutic license, correct?

A. Correct.

Q. And you have indicated that your continuing education has trained you on the diagnosis

Page 198

of glaucoma, correct?

A. Correct.

Q. Okay. And you said you understood film over the eye or blurry vision and halos around lights were symptoms of glaucoma, correct?

MR. WHITE: Asked and answered. We're going to keep going back through the same series of questions and answers every time you get ready to ask a question?

MR. ADAMS: You know, he's a very artful -- he's very artful at avoiding the questions.

MR. WHITE: You have a right to ask a question, but you don't have the right to ask the same question over and over and over again.

MR. ADAMS: Well, it seems that when I ask a question, we end up having to back up and

Page 199

dissect it and go bit by bit. And that --

MR. WHITE: That may be, but that doesn't give you the right to go back and ask the same question over and over again, the one that he's answered.

MR. ADAMS: If he needs a foundation laid to answer every question, then I've got to go back and do that. Your objection is in the record.

Q. Now, these symptoms of glaucoma that Kyle Bengtson presented with on August 20th, 2004 called for the ruling out of some form of glaucoma in his right eye. Agree or disagree?

A. The symptoms that Kyle showed on that visit showed that he had some diminished vision as far as the clarity of the vision that he was getting with the right eye, and my job is to find a cause of that. And that cause was detected, it was demonstrated to him,

Page 200

and it was taken into effect by changing the glasses.

Q. When Kyle came in to pick up a copy of his record after he left Dr. Sepanski's office in March of 2005, did you immediately give him his record?

A. Personally, I didn't hand it to him. Someone would have come and asked me, and I would have said okay and made a note on the chart, and they would have given it to him.

Q. Okay. But are you aware that that is not what his testimony is going to be? Are you aware that he waited for nearly an hour on his record?

A. I don't know.

Q. Do you remember him coming in asking for his records?

A. In all honesty, no.

Q. Were all of these records made contemporaneous with the treatment given?

A. Can you rephrase that for me?

Q. Were all of these records made at the time of Kyle's visit?

Page 201

A. I'm not sure. I guess we could get that if you needed to.
Q. I'm asking you if you made any late entries on his record.
A. I don't recall making any.
Q. Okay.
A. I wrote an entry on his record that he wanted a copy of his records. Is that what you're asking?
Q. No. I'm asking you when do you make -- when did you make Kyle's record? Was it at the time he came in and saw you, or do you make the record after he's gone?
A. No. When we're through and we've gone over the findings, then this is put in his chart and put up.
Q. Okay. And how long after his visit is that done?
A. It depends on how long the people up front take to take care of what he was going to have done up there as far as getting glasses or contacts or nothing or what.
Q. What is the longest you would wait to make

Page 202

a record like this on a patient who's left your office?
A. Longest? I'm not sure what you're asking.
MR. WHITE: You're asking longest when he writes it down? I don't think y'all are communicating.
Q. How long does it take typically after a patient leaves for you to complete this record?
A. Isn't that what I just answered?
Q. No.
A. Okay. Can you rephrase it another way, then?
MR. WHITE: He's asking you when you write down -- when you write it down on the sheet of paper.
A. That's what I said a minute ago. After I finish this, this is done before he ever leaves my presence.
Q. Okay.
MR. WHITE: That's what he's

Page 203

asking you.
Q. Okay. I didn't understand that.
What are the chances that any of this was -- Strike that.
Is it your testimony that youare not aware of any entry made after Kyle Bengtson left your office?
A. Just the one about his request for copies of the record.
Q. I haven't seen that, I don't believe.
I was trying to ask this earlier, but somehow we got thrown off. Given the fact that you knew that on a prior visit the puff test didn't work for Kyle, shouldn't you have used Goldmann's tonometry?
A. If there had been any sense of abnormality in the reading that we got that day, I would have done a Goldmann tonometry just like I did on the visit before that when there was a nonreading.
Q. Okay. Do you agree that good optometric care requires you to be attentive to the way patients have responded to certain

Page 204

tests in the past?
A. Usually if you discuss the -- whether it be any of the tests that are on this page and they had trouble with them before, then I'll usually spend some time, you know, discussing with them the way to make that test result be better, and generally that's good enough.
Q. Did you discuss Goldmann's tonometry versus the puff test with Kyle on August the 20th, 2004?
A. No, I wouldn't have done that.
Q. Why not?
A. There was no indication to do that.
Q. Well, he had had a puff test on a prior visit where you said it didn't work -- didn't work right.
A. Right.
Q. So you had to use the Goldmann's.
A. But on this visit here, it worked just fine.
Q. But because he presented with these signs and symptoms of angle closure glaucoma, you

Page 205

had to be extra concerned and extra careful about an accurate reading of his intraocular pressure, correct?
MR. WHITE: Object to the form.
A. We did several tests that would have to do with him having angle closure glaucoma, and generally -- I don't know how much you've gotten to read in your book, but in angle closure glaucoma there is a tremendous asymmetry in the pressure between one eye and the other, as much as 30 or 40 points. The difference between 13 and 12 is one.
Q. Okay. But there were other tests available to you in the office that day, and you did not use them to measure his intraocular pressure, correct?
A. That's correct.
Q. Okay. And there were other ways of viewing his angle other than the slit lamp exam, and you didn't use those either, correct?
A. We did use a slit lamp exam.
Q. But you didn't use anything else?
A. To look in the anterior chamber angle?

Page 206

Q. Right.
A. No. We used the test that you use the slit lamp for, which was the von Herrick method.
Q. Okay. But the gonioscopy provides a superior view. Okay.
MR. ADAMS: You want to take a break? And I'd like that copy of the written history if we could. Thank you.
MR. WHITE: Sure.
(Brief recess.)
MR. ADAMS: I'm just going to right now -- I don't necessarily know that there's anything that I want to ask about here, but let's just attach it somehow. We'll just make that a part of this exhibit.
Q. (Mr. Adams continuing) And let me ask you, Dr. Bazemore. You agree that that is a form used by your office, correct?
A. Correct.

Page 207

Q. And it appears to be filled out by Kyle Bengtson at his visit -- apparently, his first visit?
A. Right.
Q. Okay. So that would go with the 2000 note, for the year 2000, like March 24th?
A. It would have been filled out then.
Q. All right. Thank you.
When Kyle Bengtson came in to see you on August the 20th, 2004, what eye problems do you believe he had at that time?
A. There were no problems found except for his refractive error. In the left eye, there was no change from the time before. In the right eye, there was a correction for astigmatism change, so it was recommended that he change the right lens in his glasses after a positive demonstration of the change was given to him.
Q. Okay. But other than changing his prescription and having him come back for recheck in one year, you didn't refer him for more tests or ask him to come back or

Page 208

anything like that, correct?
A. There were no other problems detected.
Q. So no referral to an ophthalmologist?
A. That's correct.
Q. And just so I understand, why did you not ask him to follow up with you sooner than one year?
A. There were no findings that would have indicated that he come back any sooner than that.
Q. Okay. And why no referral to an ophthalmologist?
A. There was no problems detected that would indicate that that be done.
Q. Okay. If a patient has had trauma to his eye in the past, can that cause angle closure glaucoma?
A. It could possibly cause a secondary type.
Q. And the standard of care in terms of your duty to be diligent in treatment and diagnosis is the same regardless of the origin of the angle closure, correct?
A. That's correct.

Page 209

Q. Or the origin of the symptoms, correct?
A. The origin of the symptoms, I'm not sure -- you would have to be more specific than that.
Q. Yeah, you're right. That's not a real good question.
It doesn't matter -- your duty doesn't change if somebody comes in with glaucoma pursuant to an injury or glaucoma pursuant to some other cause, does it? Your duty to provide good care is the same, correct?
A. My duty is to try to figure out if they do have glaucoma, and if they do, then to try to get something done about it.
Q. Whether or not that glaucoma originates from an injury or some other cause, right?
A. That's true.
Q. Okay. How could the gonioscopy have aided in the diagnosis of narrow angle glaucoma in Kyle Bengtson?
MR. WHITE: Object to the form.
A. Somebody who actually saw him when he had angle closure glaucoma would be better able

Page 210

to answer that question. I don't know exactly what was going on with him at that time. It wasn't doing that when I saw him.
Q. Okay. Whether or not he had a closed angle at the time he came to see you, based on his complaint that he was seeing halos around lights, why was the gonioscopy not performed?
A. There was no indication to perform it.
Q. Would Goldmann tonometry have aided you in your diagnosis?
A. No more so than what we had already.
Q. And are Goldmann tonometry and applanation tonometry the same thing?
A. There are other kinds of applanation tonometry.
Q. I'm just going to show you this. We may make it an exhibit, but -- I'll show it to your attorney. That's just something I found on the internet, and I'll be glad to share a copy with your lawyer if you want to. This is just something that --
MR. WHITE: You want him to read

Page 211

it?
MR. ADAMS: I'm just going to ask him about it.
MR. WHITE: He needs to read it first.
Q. Well, you can read it. Sure. No problem.
MR. WHITE: Well, and we're not going to answer questions about it unless you're going to make it an exhibit to the deposition.
MR. ADAMS: That's fine. I'll make it an exhibit. That's fine.
(Plaintiff's Exhibit 6 was marked for identification.)
Q. I'm just going to ask you about the middle paragraph there on the symptoms.
MR. WHITE: I don't think he's finished reading it. I know I'm not. We just finished the first paragraph.
MR. ADAMS: All right.

Page 212

Q. Okay. If you don't mind, just put this down on the table where we can both look at it.
A. Okay.
Q. All right. Where it says symptoms of narrow angle glaucoma, you agree with me that it says cloudy cornea there?
A. Correct.
Q. Blurring and decreased visual acuity. Do you see that?
A. Correct.
Q. Seeing halos around lights. Do you see that?
A. Well, I saw it, yes.
Q. All right. Are you aware that this kind of information -- I'll just represent to you that this kind of information regarding the signs and symptoms of angle closure glaucoma is readily available to a layman over the internet. Are you aware of that?
A. I would think probably so.
Q. Okay.
A. If they looked under -- you could do it

Page 213

under Google or under Mayo Clinic or something like that.
Q. Yeah. And I'm not going to take the time to go through everything, but I got one from Emedicine Health, one from IMD.
A. Right.
Q. And it all has halos around lights, blurry vision --
A. Correct.
Q. -- cloudy cornea.
Why do you think that this type of information is so readily available to the public as being a symptom of narrow angle glaucoma, yet you, apparently, were not concerned about glaucoma when Kyle Bengtson presented with these symptoms on August the 20th?
MR. WHITE: Object to the form. That's a compound and confusing, misleading statement. You're going to have to break that down. First you asked why is it on

Page 214

the Internet, and then you said something about you apparently disregarded the information.
Q. Do you have an answer?
MR. WHITE: He's not going to answer that question as asked. If you want to break it down into two questions, you can ask it again.
A. Have to break it down some.
Q. If a patient presented to you with these symptoms, the same symptoms that Kyle Bengtson presented on August the 20th, 2004, what tests would you run?
A. I would run all of the tests that we did this day. And if they were -- the results were the same on them, then I would have taken the same treatment plan.
Q. You wouldn't do the Goldmann's tonometry?
A. No.
Q. And you wouldn't do the gonioscopy?
A. No.

Page 215

Q. Okay. But at least as of a few hours ago, I presented you with academic literature saying that that is the proper battery of tests.
MR. WHITE: Object to the form.
A. It said that it was the appropriate test if other things applied to that patient which did not apply in Kyle's case.
Q. Isn't it your job as an optometrist to eliminate the concern that Kyle may have a blinding disease like glaucoma?
A. Yes. And that's why we checked the pressure in his eye. That's why we looked at his optic nerve. That's why we did a screening for the depth of his anterior chamber angle. That's why we checked his pupil reflexes. That's why we did confrontation visual fields. All of those are useful in diagnosing glaucoma, and they were all normal.
Q. Okay. What causes seeing halos around lights?
MR. WHITE: Asked and answered.

Page 216

MR. ADAMS: He hasn't answered that.
A. About three times.
Q. I said what causes it. It's different. What causes it?
A. Anything that interferes -- let's see. Let me use an analogy. If you're riding down the road and you hit a big splash of some kind of crud on your windshield, and you look at the headlight coming the other way, it's going to have all kinds of different beams and just distortion to the image of the headlight. So if he has cataracts, if he has glaucoma scarring -- I mean, if he has corneal scarring, if he has a refractive error such as an increase in the amount of astigmatism, if he has a retinal problem, all of those things could cause those symptoms.
Q. Okay.
A. And some more.
(Plaintiff's Exhibit 7 was marked for identification.)

Page 217

Q. All right. Let me hand you what I'm going to mark as Plaintiff's Exhibit 7. Do you recognize this document? I'm not going to ask you about this whole thing. Just kind of --

MR. WHITE: Do you recognize it?

THE WITNESS: Yes.

Q. Okay. This is your license agreement between Wal-Mart and you, correct?

A. Correct.

Q. Okay. All right. Is everything in here true and correct? I mean, this agreement -- Well, you can go ahead and answer that one, and then we'll ask the next one.

MR. WHITE: Do you know what the question is?

Q. Is this an accurate --

A. I'm just looking through to make sure all of it is right.

Q. This is an accurate -- this document is your license agreement, correct?

A. So far it is.

Page 218

Q. Okay.

A. I'm looking to make sure.

Q. Sure.

All right. Has this agreement been modified in any way since it was written February 28th, 2004?

A. Not to my knowledge.

Q. Okay. And if it were modified, you and Wal-Mart would have to do that --

A. Correct.

Q. -- together? It couldn't be just done by one party, right?

A. No.

Q. Okay. Look at page six, if you would, section 12. It says that Wal-Mart licensor -- in other words, which is defined as Wal-Mart -- says that they shall at any and all times have full right to enter upon the premises herein licensed for any lawful purpose.

Do you see that?

A. Okay. What was the question?

Q. Well, paragraph 12 says that Wal-Mart can

Page 219

come into the leased area of the store at any and all times. Do they have open access to your store? Does a representative of Wal-Mart have the right to come and go in your optometry store, say, even after it's locked up?

A. Y'all are the lawyers. I don't know.

Q. I'm asking you, do they --

A. I've never had that happen.

Q. Okay. Do they have a key to your optometry shop?

A. The store manager people have a key where they can come in in case of emergencies and stuff.

Q. Okay. But do they come in for any other reasons?

A. Not that I'm aware of.

Q. Okay. Paragraph 10, it says that you do not have the right or authorization to assign or sublicense any part of the licensed premises to anybody else.

Do you understand that to mean that you cannot like subcontract any of your duties

Page 220

or obligations under this agreement?

MR. WHITE: Object to the form. I mean, the document says what it says. It's a signed document between he and Wal-Mart, but --

Q. Okay. Well, I'm just asking. Is it a fair reading of this that you're not permitted to --

Let's just say you got tired of doing what you're doing. You couldn't just go find a new optometrist and say, hey, you know, here, work at Wal-Mart under my agreement. You're not permitted to do that, are you?

MR. WHITE: Object to the form. You can answer if you know.

A. Sometimes someone from one store will cover for someone from the other store if there's illness or death in the family or things such as that, if that's what you're asking.

Q. Well, not exactly, but --

I mean, have you ever tried to get out

Page 221

of this agreement?
A. No.
Q. Okay. And do you know if you could get out of this agreement and, like, assign your rights or sell your rights under this agreement to another optometrist?
A. No. All I can do is break the agreement with Wal-Mart.
Q. Okay. Are you free to break the agreement?
A. With a notice.
Q. Okay. And that's helpful to know. They've got to give you a 60-day notice. Is that what you understand?
A. What page are you on on there?
Q. Page one. If they want to break the agreement --
MR. WHITE: What paragraph are you at?
MR. ADAMS: It's the last paragraph on the page. Licensor shall whenever possible provide licensee with 60 days notice with proposed

Page 222

closure of the licensed premises and/or vision center.
MR. WHITE: Okay.
A. And what that says is if they close the vision center in that store, they have to give you a 60-day notice.
Q. Right. And what kind of notice do you have to give them if you want to get out of this?
A. It's in here somewhere.
Q. Okay. I see it on page three. It is agreed and understood that licensee shall have the right to terminate this agreement upon the giving of 60-days notice in advance of termination. Okay.
And when you said earlier that they give you a money order, what I understand is they collect the money for you, and at the end of the day you get a money order for 90 percent of what they collected; is that right?
A. The percentage varies depending on other things that are flexible within the

Page 223

agreement, but they collect part of -- part of the operation is for them to collect all the fees for me, and I pay them a percentage for that and other jobs that they do to help me.
Q. Okay. If you can't rule out the prospect of a certain eye disease, what is your duty?
A. I'm sorry?
Q. If you can't rule out the prospect of a certain eye disease, what is your duty to the patient?
A. To have him see somebody that can.
Q. Okay. Do you know Dr. Richard Murphy, an optometrist?
A. Oh, okay. Yes.
Q. Is he a friend of yours?
A. No, not really. I haven't seen him in a while.
Q. Okay. When was the last time you saw him?
A. I think it's been about two or three years. We ended up in the same CE conference.

Page 224

Q. Are you aware he's given an expert opinion in your case?
A. Yes.
Q. Okay. In his affidavit or his opinion, he stated that -- his report, rather -- he said, it is my opinion that Dr. Bazemore, like any other practicing optometrist, could not have predicted the tragic sequence of events that led to plaintiff's vision loss.
Do you agree that there was a tragic sequence of events here?
MR. WHITE: Object to the form. You can answer.
A. I think it's unfortunate that he had a problem with his eye, if that's what you're asking.
Q. Do you agree that no medical professional could see into the future, really? I mean, correct?
A. I haven't met one yet.
Q. Right. Y'all aren't in the crystal ball business, are you?

Page 225

A. No.
Q. Okay. Do you agree that because you can't predict what lies ahead, you have to prepare for the worst?
MR. WHITE: Object to the form.
A. No, I don't agree with that.
Q. Why not?
A. Well, do you sleep in the basement in case you have a tornado?
Q. I don't have a basement, but anyway. If you see a tornado coming, do you sleep in your basement?
A. If I saw one coming, I would.
Q. Because you're concerned for your safety, correct?
A. That, and more so my family's.
Q. And as an optometrist, it's your duty to be concerned for the safety of those people who come to you as patients, correct?
A. That's what they're coming in for.
Q. And it is your job to see --
As you said in the first few minutes of this deposition, you are an optometrist,

Page 226

correct?
A. That's correct.
Q. And you are trained to examine eyes for eye problems such as glaucoma, correct?
A. Correct.
Q. And therefore, you are required to know the symptoms of glaucoma, correct?
A. Correct.
Q. So that you can see such a problem as glaucoma coming before it causes too much damage, correct?
MR. WHITE: Objection to the form. You can answer.
A. Well, glaucoma is not very predictable in the sense that until there are symptoms, you can't diagnose them as having them or not or signs. And the only way you can tell if they have it is through verification of different defects which we've already covered and gone through some of that.
Q. And the verification requires the implementation of your best tools, correct?

Page 227

A. It would depend on what kind of problems you detected as to what should be done next.
Q. Okay. All right. I'm done.
* * * * * * * * * * * * *
FURTHER DEPONENT SAITH NOT
* * * * * * * * * * * * *
REPORTER'S CERTIFICATE
STATE OF ALABAMA:
MONTGOMERY COUNTY:
I, Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of Alabama at Large, do hereby certify that I reported the deposition of:
DAVID BAZEMORE, O.D.
who was first duly sworn by me to speak the truth, the whole truth and nothing but the truth, in the matter of:
KYLE BENGTSON,
Plaintiff,
vs.
DAVID BAZEMORE, O.D.,
Et al.,

Page 228

Defendants.
In The U.S. District Court
For the Middle District of Alabama
Eastern Division
Case Number 3:06-cv-00569-MEF
on May 15, 2007.
The foregoing 227 computer printed pages contain a true and correct transcript of the examination of said witness by counsel for the parties set out herein. The reading and signing of same is hereby waived.
I further certify that I am neither of kin nor of counsel to the parties to said cause nor in any manner interested in the results thereof.
This 30th day of May 2006.

Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of Alabama at Large

T

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NAME Bengtson, Kyle DATE: 8-20-04
DOB 1-12-77 (27 y/o) ADDRESS 2499 Lee Rd 84 [illegible]
SEX M PHONE 887-2590
RACE C SPONSOR

V.A.	uncorrected dist	near	HABITUAL Rx sph	cyl	axis	add	prism	corrected dist	near
O.D.	100		-.25	-1.25	92	UltraFlex, DW			
O.S.	40		-1.00	DS		8.6/14/ -1.00			
O.U.						-1.00			

P.D.

HX: last eye exam: 9-27-03 Reason: [illegible] problem w/ OD eye feels like film
[illegible] & OD has "film" over it; is worse @ [illegible]; see "halos" around lights; been that way ≈ 2 mos, c minor worsening
General Health: good
Medications: no
Drug Allergies: NKDA
Ocular History: no [illegible] PTK [illegible]

Cover Test (sc/cc) ortho
Vergences
Ext. [illegible]
Versions [illegible]
NPC [illegible]
Pupils [illegible]
Acc. [illegible]

	RET.	V.A.	Subj.	V.A.	Near	V.A.
O.D.	clear		-50-250x94	20/25+		
O.S.			-100 DS	20-		
Monoc x-cyl						
Binoc x-cyl			PRA			
			NRA			

Stereopsis
Color Vision plates 8 misses 0 [illegible]
Misc: Confrontation OD [illegible] FTFC [illegible] quads

Keratometry O.D. 44.00/45.50
O.S. 44.75/44.75 [illegible]

SLE [illegible] [illegible] [illegible]
Oph [illegible] 135 [illegible]

Tonometry NCT @ 10:20 am
13 mmHg
12

IMP: A) [illegible] & [illegible] OD; [illegible] BCVA OD

PLAN: A) [illegible] to [illegible] + [illegible]
OD -50-250x94
[illegible]

$117.00

PLAINTIFF'S EXHIBIT 5
PENGAD 800-631-6989

NAME [illegible] DATE: 9/27/03

DOB [illegible] ADDRESS [illegible]

SEX [illegible] PHONE [illegible]

RACE [illegible] SPONSOR 84

V.A.	uncorrected dist	near	HABITUAL Rx sph	cyl	axis	add	prism	corrected dist	near
O.D.	20/50		[illegible]		[illegible]	-100			
O.S.	40					-075			
O.U.									

P.D.

HX: last eye exam: [illegible] 10/01, new c/s [illegible] part-time [illegible] update c/s

Reason:

General Health: [illegible]

Medications: [illegible]

Drug Allergies: NKDA

Ocular History: [illegible]

Cover Test sc cc [illegible]

Vergences

Ext. [illegible]

Versions [illegible]

NPC [illegible]

Pupils [illegible]

Acc. [illegible]

	RET.	V.A.	Subj.	V.A.	Near	V.A.
O.D.	[illegible]		-25-125 x 92	20/20		
O.S.			-100	20		

Monoc x-cyl PRA

Binoc x-cyl NRA

Stereopsis Misc: Confrontation

Color Vision plates ___ misses ___ [illegible] OD FTFC OS FTFC [illegible]

Keratometry O.D.

O.S.

SLE [illegible]

Oph [illegible] C/D .35 .35 [illegible]

Tonometry NCT @ 12 / 14 [illegible] 8:50

[illegible]

IMP: [illegible]

PLAN: [illegible] (OD) -25-125 x 92 (OS -100)

$47.00

[illegible]

NAME Bengtson, Kyle DATE: 10-02-01
DOB 1-12-79 ADDRESS 326 Lee Rd 649 [illegible] AL 3685[illegible]
SEX M PHONE 887-2580
RACE C SPONSOR

V.A.	uncorrected dist	near	HABITUAL Rx sph	cyl	axis	add	prism	corrected dist	near
O.D.	60		-.50	-.25	95				
O.S.	40		-.50	-.25	10				
O.U.									

P.D.

Hx: last eye exam: 3-24-00 Reason: Rt exam - wants (new wear) contacts
[illegible] new glasses General Health: No
[illegible] Medications: No
[illegible]
[illegible] Drug Allergies: NKDA
Cover Test sc cc Ø / Ø
Vergences Ocular History: No s ocular Hx
Ext. [illegible]
Versions [illegible]
NPC [illegible]
Pupils PERRLA neg MG
Acc. NRA

	RET.	V.A.	Subj.	V.A.	Near	V.A.
O.D.			-.75 -.25 x 100	20/20		
O.S.			-.75 DS	20/20		

Monoc x-cyl
Binoc x-cyl PRA [illegible]

Stereopsis
Color Vision plates 8 misses 0 Misc: Confrontation OD FTFC OS FTFC all quads
Keratometry O.D. 44.62/45.00
O.S. 44.50/44.87

SLE [illegible] Oph [illegible]

Tonometry NCT @ 3:50pm TA 20/19
[illegible] 38 / 24 PLAN: New CL Fit
[illegible]
8.6/14.0/-1.00 / -.75
[illegible]

LAST, FIRST
NAME Bengtson, Kyle
DATE: 3-24-00
DOB 1-12-77 AGE: 23
ADDRESS 356 Lee Rd 649 Waverly
SEX M
PHONE 887-2580 ID #: A136879
RACE W
INSURANCE: GROUP #

V.A.		uncorrected dist	near	HABITUAL Rx sph	cyl	axis	add	prism	corrected dist	near
	O.D.	60-1			None					
20/	O.S.	50-1								
	O.U.									

P.D.

Rx: LAST EXAM DATE: Never had one

REASON FOR VISIT: Pt exam having pro seeing far away

CC: ↓ ∞ va noticed last several weeks, near VA ok

MEDS:

KNOWN DRUG ALLERGIES:

OCULAR HISTORY:

Cover Test: ortho
Vergences
Ext.: unrem
Versions: full
NPC: to
Pupils: perrla negative
Acc.: NA

	RET.	V.A.	Subj.	V.A.	Near	V.A.
O.D.	cleared		-25-50x95	20/20		
O.S.			-50-25x10	20/20		

Monoc x-cyl
PRA
Binoc x-cyl
NRA

Stereopsis
Misc: C-FTFC OD & OS All quads
Color Vision COLOR PLATES: 0 MISSES

Keratometry O.D. 44.50 | 44.87
O.S. 44.50 | 45.12

SLE: lids/lashes clear
Opth: C/D 0.35 OU

Tonometry NCT @ 3:00pm
17
IMP: 16

PLAN: Rx glasses DVO
OD -50-25x95
OS -50-25x10

DR. DAVID N. BAZEMORE
OPTOMETRIST

PATIENT REGISTRATION FORM

Patient's Name:_____

Parent's Name: _____
(If Patient Is A Child)

Mailing Address:_____

Date Of Birth:
/ / 19__ _____

Age: ___ _____
City State Zip

Home Phone:_____Work:_____

Occupation:_____Employer:_____

If Student-Grade:_____School:_____

Who May We Thank For Referring You To Us?

_____

Will Today's Exam Be Paid For By (Circle One)

Cash- Check-Credit Card- Insurance-Other

1. What is your reason for seeking vision care at this time?

2. Do you have any general health problems?

3. Are you taking any medications?

4. Are you allergic to any medications?

5. Have you ever had any injuries, operations or infections involving your eyes?

6. Is there any family history of eye disease such as Cataracts or Glaucoma, in your family?

7. Do you have a lazy eye? Right or Left

_____
Signature

DATE:

ADDRESS

PHONE

SPONSOR

	uncorrected dist	near	HABITUAL Rx sph	cyl	axis	add	prism	corrected dist	near
O.D.									
O.S.									
O.U.									

P.D.

st eye exam:

Reason:

General Health:

Medications:

Drug Allergies:

est sc cc

os

s

Ocular History:

RET. V.A. Subj. V.A. Near V.A.

x-cyl PRA

-cyl NRA

sis

vision plates ___ misses

Misc: Confrontation OD OS

metry O.D.

O.S.

Opth

etry NCT ②

PLAN:

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
				X			[illegible]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[illegible]	1 [illegible] 57 M X F	[illegible]

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[illegible]	Self X Spouse Child Other	[illegible]

CITY	STATE	8. PATIENT STATUS	CITY	STATE
[illegible]	[illegible]	Single X Married Other	[illegible]	[illegible]

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
[illegible]	(334) 887-3587	Employed X Full-Time Student Part-Time Student	[illegible]	( ) [illegible]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		[illegible]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [signature] DATE 10/2/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILIAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. [illegible] 3.

2. 4.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 [illegible]			[illegible]		[illegible]	[illegible]					
2 [illegible]			[illegible]		[illegible]	[illegible]					
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
[signature]		
SIGNED DATE		PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single, Married, Other	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed, Full-Time Student, Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILIAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED DATE		PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

[illegible]

BLACK LUNG AND FECA CLAIMS

[illegible] ...basic coding system.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

[illegible] ...ication.

[illegible]

...ther certify that the services performed were for a Black Lung-related disorder.

[illegible]

...TICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

...are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and ... USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

...he information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services ...supplies you received are covered by these programs and to insure that proper payment is made.

...e information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

...R MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

...R OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, ...90, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

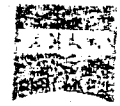
...R CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

...UTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment ... [illegible] ... CHAMPUS.

[illegible]

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

[illegible]



Humphrey

VD = 12.00

S	C	A
- 0.75	-0.50	101
- 0.50	-0.75	105
- 0.75	-0.50	99
- 0.75	-0.50	100

S
- 0.75
- 0.75
- 1.00
- 0.75

PD = 6.0mm

RT. DATA

D	MM	A
44.62	7.56	13
45.00	7.49	103
44.37	7.52	AVE
CYL	-0.37	15

D	MM	A
44.50	7.58	167
44.87	7.52	77
44.62	7.55	AVE
CYL	-0.37	167

DR. DAVID N. BAZEMORE
OPTOMETRIST

PATIENT REGISTRATION FORM

Patient's Name: Kyle Bennett

Parent's Name: _____
(If Patient Is A Child)

Mailing Address: 326 Lee Rd 649 Waverly AL 36879

Date Of Birth: 1/12/ 1977

Age: 23

Waverly AL 36879
City State Zip

Home Phone: 887 2530 Work: 502-7100

Occupation: Carpenter Employer: 1st Team Const.

If Student-Grade: _____ School: _____

Who May We Thank For Referring You To Us?

_____

Will Today's Exam Be Paid For By (Circle One)

Cash- Check-Credit Card- Insurance-Other

1. What is your reason for seeking vision care at this time? Need bifocal lenses

2. Do you have any general health problems? no

3. Are you taking any medications? no

4. Are you allergic to any medications? no

5. Have you ever had any injuries, operations or infections involving your eyes? no

6. Is there any family history of eye disease such as Cataracts or Glaucoma, in your family?

7. Do you have a lazy eye? Right or Left

K L Bennett
Signature